Sept. 10, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: (CMS-1693-P) Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Administrator Verma:

The National Association of ACOs (NAACOS) is pleased to submit comments in response to the proposed rule, *Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program*.

NAACOS is the largest association of ACOs, representing more than 6 million beneficiary lives through 360 Medicare Shared Savings Program (MSSP), Next Generation, and commercial ACOs. NAACOS is an ACO 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. Our members, more than many other healthcare organizations, want to see an effective, coordinated patient-centric care process. Our recommendations reflect our expectation and desire to see ACOs achieve the long-term sustainability necessary to enhance care coordination and health outcomes for Medicare beneficiaries, reduce healthcare costs, and improve quality in the Medicare program.

Summary of Key Recommendations

As detailed in the comments below, in the final 2019 Medicare Physician Fee Schedule (PFS) we urge the agency to:

- **Finalize proposals to reduce Evaluation & Management (E/M) documentation burdens but not move forward with collapsing payment amounts for eight office visit services for new and established patients down to two due to concerns about patient access to care;**
- **Finalize adding new Chronic Care Management (CCM) code 994X7 to the Physician Fee Schedule beginning in 2019 with an increased work valuation;**

- **Finalize new opportunities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to receive payment for communication technology-based services and waive face-to-face requirements;**
- **Adopt changes detailed below concerning proposed deletions and additions to the MSSP quality measure set;**
- **Finalize proposals to pay separately for Brief Communication Technology-Based Service (GVCI1) and Remote Professional Evaluation of Patient-Transmitted Information Conducted Via Pre-Recorded Store and Forward Video or Image Technology (GRAS1) with modifications described below;**
- **Eliminate patient copays for newly proposed digital, communication technology, and care management services and avoid imposing burdensome billing requirements associated with such services that could impede widespread adoption;**
- **Finalize proposed payment for interprofessional consultations performed via communications technology such as telephone or internet (CPT Codes 994X6, 994X0, 99446, 99447, 99448, and 99449);**
- **Do not finalize proposals to reduce Medicare reimbursement for new drugs from Wholesale Acquisition Cost (WAC) + 6 percent to WAC + 3 percent; and**
- **Require sharing of Admissions, Discharge and Transfer (ADT) information as a Condition of Participation in Medicare to further facilitate care coordination activities.**

As part of the agency's ongoing implementation of Medicare Access and CHIP Reauthorization Act's (MACRA) Quality Payment Program (QPP), we urge CMS to:

- **Address CMS's projected decrease in the number of Qualifying APM Participants (QPs) in PY 2019 by promoting policies that support ACO growth and increased provider participation in ACOs;**
- **Finalize the proposal to maintain and not increase the 8 percent revenue-based Advanced Alternative Payment Model (APM) risk requirements through 2024 and beyond for both Medicare and Other Payer APMs;**
- **Refine certain processes for the All-Payer Combination Option, including finalizing the ability to avoid annual submission requirements for details on Other Payer APM arrangements;**
- **Finalize policies for QP determinations to provide more timely, detailed information about QP determinations;**
- **Finalize proposals to raise the Merit-Based Incentive Payment System (MIPS) performance and exceptional performance thresholds;**
- **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;**
- **Finalize additional options for clinicians in ACOs reporting Promoting Interoperability while also expanding flexibility by allowing ACO entities to report on behalf of their clinicians;**
- **Provide ACOs with more detailed performance information for MIPS;**
- **Provide additional information regarding how ACOs subject to MIPS will be affected by other CMS proposals to remove ACO quality measure 11 (i.e., the Use of Certified EHR Technology); and**
- **Exclude MIPS payment adjustments as ACO expenditures.**

MEDICARE PHYSICIAN FEE SCHEDULE PROPOSALS

Evaluation & Management (E/M) Documentation and Payment Changes

Key Comment: NAACOS strongly supports CMS's efforts to reduce E/M documentation burdens but opposes CMS's proposal to collapse payment amounts for eight office visit services for new and established patients down to two due to concerns about patient access to care.

Proposals: CMS proposes a number of significant coding and payment changes related to E/M office visits. The agency proposes additional flexibility related to documentation for office or outpatient E/M visits and home visits by allowing practitioners to continue using the current framework specified under the 1995 or 1997 E/M documentation guidelines, or use Medical Decision Making (MDM) or time as a basis to determine the appropriate E/M level. CMS also proposes to assist with practitioners' focus on changes in the patient's medical history by allowing practitioners to document interval history rather than repeating information already recorded in the patient history, and CMS proposes to allow practitioners to review and certify information in the medical record rather than re-entering it. The agency proposes to apply a minimum documentation standard where, for the purposes of PFS payment, practitioners would only need to meet the documentation requirements currently associated with a level 2 visit for history, exam and/or MDM (except when using time to document the service). For practitioners choosing to support their coding and payment for an E/M visit by documenting the amount of time spent with the patient, CMS proposes to require the practitioner to document the medical necessity of the visit and show the total amount of time spent by the billing practitioner face-to-face with the patient. CMS also proposes to eliminate the requirement to justify the medical necessity of a home visit in lieu of an office visit.

In tandem with these documentation proposals, CMS proposes new, single blended payment rates for new and established patients for office/outpatient E/M Level 2 through 5 visits along with a series of add-on codes, including those for primary care and non-procedural specialty care. This would change payment for Healthcare Common Procedure Coding System (HCPCS) codes 99202–99205 from the current range of $76–$211 to a single rate of $135 and payment for HCPCS codes 99212–99215 from the current range of $45–$148 to $93. The agency proposes to create new add-on payments related to E/M services, including GPC1X, which would be for visit complexity inherent to E/M associated with primary medical care services provided to established patients. CMS also proposes to create HCPCS G-code, GCG0X, to be reported with an E/M service to describe the additional resource costs for certain specialty professionals for whom E/M visit codes make up a large percentage of their overall allowed charges and whose treatment approaches are generally reported using the level 4 and level 5 E/M visit codes.

The agency proposes to revise the multiple procedure payment reduction (MPPR) of 50 percent for the least expensive procedure or visit that the same physician (or a physician in the same group practice) furnishes on the same day as a separately identifiable E/M visit, currently identified on the claim by an appended Modifier 25. CMS proposes these E/M visit policies would be effective beginning January 1, 2019, though the agency also solicits feedback on whether implementation should be delayed to January 1, 2020.

Comments: NAACOS appreciates and supports CMS's efforts to reduce documentation burden. To deliver higher quality, lower cost patient care, ACOs require precision and efficiency and these changes

could help ACOs and their participants to better serve patients by reducing administrative burdens. In particular, we support CMS's proposals to allow practitioners to document interval history rather than repeating information already recorded in the patient history, allow practitioners to review and certify information in the medical record rather than re-entering it, and eliminate the requirement to justify the medical necessity of a home visit in lieu of an office visit. We urge CMS to consider, however, challenges related to how ACOs and other providers would adjust to these new rules operationally in such a short time period, especially given current protocols related to medical malpractice liability, electronic health record (EHR) structures, and other operational issues. The proposed documentation changes may also not bring the intended relief, since practitioners would need to continue to code and document for other purposes, such as for quality reporting, risk adjustment, medical liability concerns, prior authorization requirements, compensation and use of newly proposed add-on codes. Further, there is uncertainty around the documentation requirements for billing proposed add-on codes, which could meaningfully affect the overall documentation burdens practitioners face. While we support the proposals detailed above, we request CMS also consider these factors as the agency moves forward with efforts to reduce documentation burdens.

NAACOS has significant concerns in regard to CMS's proposal to institute new, single blended payment rates for new and established patients for office/outpatient E/M Level 2 through 5 visits. We believe that this policy, if finalized, will have the unintended impact of disadvantaging those providers who care for the sickest patients, such as subspecialists, and ultimately threaten access to care for critically ill patients. We also have operational concerns; for example, many ACOs currently use RVUs to set and adjust compensation, and they are uncertain how practitioner compensation and related compliance considerations may be impacted if the payment for Levels 2 through 5 is collapsed. We are also concerned that this policy may have the unintended impact of driving up utilization and volume, an outcome which would be detrimental to the mission of ACOs and the patients they serve. This unintended consequence would emphasize volume over value, which is counterproductive to the broader shift to value-based care and payment. An alternative, and also troubling unintended consequence, would be that providers potentially reduce their Medicare patient volume or limit the medical issues addressed during one office visit, which could hinder access to care and create inconveniences and expenses for Medicare beneficiaries. As part of these concerns, NAACOS recommends CMS not finalize its proposed MPPR policy that would reduce payment by 50 percent for the least expensive procedure or visit performed on the same day as an E/M service, as this policy could have unintended consequences such as creating incentives for patients to be required to return for multiple appointments which conflicts with goals of coordinated, streamlined care.

Finally, a January 1, 2019 implementation date is not reasonable in light of the magnitude of these proposed changes. We urge the agency to ensure it has sufficiently addressed concerns and answered outstanding questions about these proposed changes and not move forward with a January 1, 2019 implementation date.

Determination of Work, Practice Expense (PE), and Malpractice Relative Value Units (RVUs)

Key comment: NAACOS requests CMS continue to phase in significant RVU updates so as not to create a disconnect between ACO expenditures and historical benchmarks.

Proposals: CMS proposes a new direct input methodology for pricing of certain supplies and equipment, which the agency would phase in over four years. CMS notes that in some cases changes

to Practice Expense (PE) values could have significant implications for reimbursement of certain CPT codes. Further, while CMS is normally required to phase-in "significant" RVU changes over multiple years, the agency proposes a mechanism to allow certain large PE changes to take effect immediately, if based on actual invoice data.

Comments: NAACOS understands the need to regularly update RVU values based on new information and developments in the health care industry. However, significant reimbursement changes that go into effect immediately without being phased in over time can cause unexpected variation between an ACO's costs and its historical benchmark unrelated to its actual performance. Therefore, we urge the agency to phase in significant reimbursement changes as is normally required.

Chronic Care Management (CCM) Services

> **Key comment: NAACOS requests CMS finalize adding new CCM code 994X7 to the Physician Fee Schedule beginning in 2019 with an increased work valuation.**

Proposals: For CY 2019, the CPT Editorial Panel created CPT code 994X7, which describes situations when the billing practitioner is doing the care coordination work that is attributed to clinical staff in CPT code 99490. Beginning in 2019, CMS proposes to add the new 994X7 code to the PFS, which would correspond to 30 minutes or more of CCM furnished by a physician or other qualified health care professional and is similar to CPT codes 99490 and 99487.

Comments: We support CMS continuing to add newly developed CCM services to the Physician Fee Schedule, including CPT code 994X7. We request the agency implement a higher valuation of the work component for code 994X7 than what is proposed. The final PFS valuation for this code should be increased to reflect the level of knowledge when a physician personally performs CCM, which is typically reserved for cases that are more complex and deserving extra attention.

Payment for Care Management Services and Communication Technology-based Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

> **Key comment: NAACOS appreciates CMS proposing new opportunities for RHCs and FQHCs to receive payment for communication technology-based services and urges the agency to finalize these services along with waiving face-to-face requirements.**

Proposals: CMS proposes to update the payment for the General Care Management code G0511 to reflect the input of the new CCM code 994X7. CMS also propose that RHCs and FQHCs would be eligible to receive payment for communication technology-based services or new remote evaluation services. CMS proposes to create a new Virtual Communications G code for use by RHCs and FQHCs only, with a payment rate set at the average of the PFS national non-facility payment rates for HCPCS code GVCI1 for communication technology-based services, and HCPCS code GRAS1 for remote evaluation services. RHCs and FQHCs would be able to bill the Virtual Communications G-code either alone or with other payable services. The agency also proposes to waive the RHC and FQHC face-to-face requirements when these services are furnished to an RHC or FQHC patient.

Comments: NAACOS generally supports updating existing codes to reflect new input codes that are added to the Physician Fee Schedule, and we therefore support doing so for G0511 to reflect the input of the new CCM code 994X7. We are very appreciative of CMS proposing new opportunities for providers, including those in RHCs and FQHCs, to receive payment for communication technology-

based services, and we fully support the addition of HCPCS codes GVCI1 and GRAS1. We urge the agency to finalize these codes along with waiving the face-to-face requirements when these services are furnished to an RHC or FQHC patient.

Proposed Changes to the MSSP Quality Measure Set

Key Comments:

- **NAACOS urges CMS to finalize proposals to remove the following measures from the MSSP quality measure set: ACO-35, ACO-36, ACO-37, ACO-44, ACO-12, ACO-13, ACO-15, ACO-16;**
- **NAACOS supports CMS's proposals to add ACO-45 and ACO-46 to the MSSP quality measure set;**
- **NAACOS recommends CMS make modifications to ACO-47 and ACO-41, as detailed below; and**
- **NAACOS urges CMS to implement a carve-out exception for CAHPS survey measures if these measures are deemed to be unreliable.**

Proposals: CMS makes several proposed changes to the MSSP quality measure set for 2019. As a result of these proposals, CMS would reduce the current quality measure set from 31 measures to 24 measures. CMS proposes to delete/retire 10 measures while adding three measures. Specifically, CMS proposes to remove the following measures from the MSSP quality measure set: ACO-35, ACO-36, ACO-37, ACO-44, ACO-12, ACO-13, ACO-15, ACO-16, ACO-41 and ACO-30. CMS proposes to add ACO-45, ACO-46 and ACO-47 to the MSSP quality measure set. CMS also seeks comment on the possibility of adding the Skilled Nursing Facility Quality Reporting Program measure, "Potentially Preventable 30-Day Post Discharge Readmission Measure for Skilled Nursing Facilities" in future program years. Finally, CMS seeks feedback on the possibility of adding quality measures related to opioid use in future program years.

Comments: NAACOS supports the agency's desire to reduce burden and minimize measures that are duplicative by reducing the MSSP quality measure set from 31 to 24 measures. We applaud CMS for its efforts to reduce burden associated with reporting low value or duplicative measures to support ACOs in their quality improvement efforts, as part of their Meaningful Measures initiative. Detailed comments on each measure change proposed are included below. We encourage CMS to continue to work with private payers who may continue to rely on such measures to promote more measure harmonization across payers, where appropriate.

ACO-35, ACO-36, ACO-37

NAACOS agrees with CMS's proposal to delete these measures due to the overlap with ACO-8, Risk Standardized, All Condition Readmission. However, we have concerns with the replacement measure being considered for ACO-35, Skilled Nursing Facility (SNF) 30-Day Readmissions. The replacement measure CMS is considering for future program years is the Skilled Nursing Facility Quality Reporting Program measure, "Potentially Preventable 30-Day Post Discharge Readmission Measure for Skilled Nursing Facilities." While the readmission window for this measure is 30 days following discharge from a SNF, there are concerns that there may still be some overlap with ACO-8. Additionally, this measure has not yet been reviewed by the National Quality Forum (NQF), and while it is currently being used in the SNF Quality Reporting Program, the measure may need to be modified for use in the ACO program.

ACO-44

NAACOS supports CMS's proposal to delete ACO-44, Use of Imaging Studies for Low Back Pain. We agree with the agency's rationale that highlights low denominator rates for ACOs due to the denominator population which looks at assigned ACO beneficiaries ages 18-50. We support CMS continuing to provide ACOs with information on their imaging use in quarterly reports provided to ACOs, as this continues to be an area of focus for ACOs in their quality improvement efforts.

ACO-12, ACO-13, ACO-16

NAACOS supports the removal of ACO-12, Medication Reconciliation Post-Discharge. This is a process measure that is considered low value due to the burden associated with the measure relative to the value the measure adds. The measure specifications make this a very labor-intensive measure that does not provide sufficient value. NAACOS supports the removal of ACO-13, Screening for Future Falls Risk, due to the fact that a replacement measure is simultaneously being proposed (see comments below). NAACOS also supports the removal of ACO-16, BMI Screening and Follow-Up. This measure is a process measure and is considered low value due to the burden associated with the measure relative to the value the measure adds.

ACO-15

NAACOS supports the removal of ACO-15, Pneumonia Vaccination Status for Older Adults, due to the fact that the measure has lost NQF endorsement. However, NAACOS believes this measure is a process measure that is considered high value given the evidence of improved outcomes associated with such vaccinations. Therefore, we urge CMS to add a replacement measure as soon as possible. This replacement measure should address key issues with the current measure, such as problems resulting from vaccination record issues that may result in patients receiving multiple vaccines.

ACO-30

NAACOS recognizes this measure has been removed from the Web Interface due to being identified as a topped-out measure. However, ACOs continue to believe this is a clinically important area and ask CMS to consider the replacement measure that has been proposed for use in the Merit-Based Incentive Payment System (MIPS) program for future program years. Any replacement measure must allow for certain exceptions related to patient-centric risk-benefit analysis and shared decision-making, especially for complex patients with multiple comorbidities, limited life expectancy, and polypharmacy. For example, CMS should allow for patient-level exceptions for medication intolerance, risks vs. benefits of the medication, and goals of care and life expectancy.

ACO-45 and ACO-46

NAACOS supports the addition of ACO-45, Courteous and Helpful Office Staff, as well as ACO-46, Care Coordination.

ACO-47

While NAACOS supports inclusion of a Falls Screening measure for MSSP ACOs, CMS proposes to replace the current ACO-13, Screening for Falls, with ACO-47, Screening, Risk Assessment and Plan of Care to Prevent Future Falls. NAACOS has concerns that this measure could add significant burden due to the prescriptive nature of the measure. Additionally, this measure, which includes additional

components such as use of a risk assessment and plan to prevent future falls, will require changes to EHRs and operational changes to capture and reflect these additional components. We urge CMS to ensure additional reporting burdens with this measure, if finalized, are minimal.

ACO-40

As CMS seeks ways to reduce burdens associated with quality reporting as part of its Meaningful Measures initiative, we urge CMS to address concerns with ACO-40, Depression Remission at Twelve Months. This measure adds significant burden, such as confusion regarding screening components that are required, and small denominators. We also urge CMS to consider the burden associated with making annual measure changes; creating new processes and having to re-educate clinicians and staff to support the data collection required for such measures is significant and should be considered as CMS contemplates changes to measures annually across multiple programs.

It has come to our attention that ACOs focused on serving the needs of long-term nursing home residents are being negatively impacted by the lack of an exceptions policy for Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures, if such measures are deemed to be unreliable due to low sample size or other reasons. The MSSP has appropriately changed is attribution logic to omit place-of-service (POS) 31 patients from participation in ACOs. The exclusion of this population has resulted in some ACOs being almost entirely comprised of long-term nursing home resident patients. Rules applicable to the administration of the CAHPS survey specifically exclude institutionalized patients, including nursing home patients, which results in potential for very small sample size of response and therefore statistically insignificant results. Solutions to this problem could include:

1. A full carve-out from CAHPS survey requirements based on ineligible population: CMS could establish a cut-off point so that CAHPS is only required when a significant proportion (such as greater than 50 percent) of the ACO population is eligible to receive the survey. If the ACO does not meet this threshold, CMS could redistribute the quality points proportionally to other domains and exempt the ACO from the CAHPS domain requirement.
2. Survey eligible population, but carve-out if data do not meet certain minimum thresholds: CMS could administer the CAHPS survey as specified to eligible non-institutionalized patients and then statistically evaluate whether the resulting margin of errors (confidence intervals) achieve a reasonable established threshold. If the margin of error does not meet the threshold, CMS could redistribute the quality points proportionally to other domains and exempt the ACO from the CAHPS requirement.
3. Alternative survey methodology: CMS could identify and substitute a validated survey of nursing home patients that assesses similar issues of provider access/experience of care as the current CAHPS survey does. Please note that the existing CAHPS Nursing Home Survey does not measure similar topics and omits provide-patient experience, which would not meet the intent of the MSSP CAHPS requirement.

NAACOS believes CMS has the authority to question the reliability of baseline data pursuant to 42 CFR 425.500(b)(2)(iii), which provides, “CMS reserves the right to use flat percentages for other measures when CMS determines that fee-for-service Medicare data are unavailable, inadequate or unreliable to set the quality benchmarks.” The data for the institutional population is unreliable for purposes of

establishing a benchmark and therefore CMS could establish a flat percentage applicable to the specific population to exempt such ACOs from this requirement.

Maintaining the current approach undermines CMS's goals of improving the quality and efficiency of care for this vulnerable population. Additionally, ACOs must meet minimum quality standards in order to be successful in the program, and for these reasons it is critical that CMS address this problem. NAACOS urges CMS to implement a carve-out exception for CAHPS survey measures if these measures are deemed to be unreliable.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

Key Comments:

- **NAACOS urges CMS to finalize proposals to pay separately for Brief Communication Technology-Based Service (GVCI1) and Remote Professional Evaluation of Patient-Transmitted Information Conducted Via Pre-Recorded Store and Forward Video or Image Technology (GRAS1) with modifications described below;**
- **NAACOS urges CMS to eliminate patient copays for such digital, communication technology and care management services; and**
- **NAACOS urges CMS to avoid imposing burdensome billing requirements associated with such services which could impede widespread adoption.**

Proposals: CMS proposes beginning January 1, 2019 to pay separately for a newly defined type of physicians' service furnished using communication technology, Brief Communication Technology-Based Service (GVCI1). This service would be billable when a physician or other qualified healthcare professional has a brief non-face-to-face check in with an established patient via communication technology to assess whether the patient's condition necessitates an office visit. CMS stipulates that when this brief communication is related to an E/M service furnished within the previous seven days by the same physician or other qualified healthcare professional, it is bundled into that previous E/M service and is not separately billable. Similarly, when the brief communication technology-based service leads to an E/M in-person visit within the next 24 hours, this would be bundled into the pre or post visit time and is not separately billable.

CMS also proposes beginning January 1, 2019 to create a specific code that describes the remote professional evaluation of patient-transmitted information conducted via pre-recorded "store and forward" video or image technology (GRAS1). This would serve as a stand-alone service only separately billable if there is no resulting E/M office visit and no related E/M office visit that occurred within the previous seven days of the remote service.

Comments: NAACOS appreciates CMS's recognition of communication technology-based services that do not meet the Medicare telehealth services definition in Section 1834(m) of the Social Security Act. We support CMS's proposal to provide payment for brief communication technology-based services HCPCS GVCI1, and we offer the following recommendations:

- We urge CMS to clarify that GVCI1 supports virtual check-ins in a modality-neutral manner so that providers will have the option to offer virtual check-ins via not only "audio-only telephone interactions" but the range of connected health tools that will enable effective collection of

patient-generated health data in follow-up to an E/M service, such as secure electronic communications.

- GVCI1 should not exclusively require direct engagement by a qualified health care professional (QHCP) during the virtual check-in, as such a requirement would discount automated tools used for virtual check-ins.
- We urge CMS to remove its proposed restriction on billing GVCI1 when the virtual check-in originates from a related E/M service provided within the previous seven days or leads to an E/M service or procedure within the next 24 hours or soonest available appointment. If CMS does not remove this restriction, it is likely to exclude numerous essential use cases from billing GVCI1 where check-ins may be medically necessary within seven days of the related E/M service or procedure (e.g., surgeries), as well as where the result in an in-person visit within 24 hours of the check-in may provide very valuable and timely medical advice to a patient.
- We encourage CMS to adjust its proposed requirement for five to 10 minutes of medical discussion to take a modality-neutral approach to virtual check-ins, recognizing that evaluation of patient generated health data can take much less than five to 10 minutes at a time, particularly when automated tools can, at intervals, identify over time whether a future in-person visit is required across a time period.
- We strongly urge that CMS waive the copay requirement for GVCI1, as copays prove to be a barrier to uptake by beneficiaries, which would hinder the success of this code and create confusion among patients.

We support CMS's proposal to provide payment for remote evaluation of recorded patient information (HCPCS GRAS1). We urge CMS to remove the proposal that this would only be separately billable if there is no resulting E/M office visit and no related E/M office visit within the previous seven days of the remote service. We believe that this constraint on the code would exclude numerous outcome-improving and cost-saving essential use cases from billing GRAS1. We also urge CMS to limit documentation and billing requirements to avoid unnecessary administrative burdens which may prevent use of the service.

Inter-Professional Internet Consultation

> **Key Comment: NAACOS supports CMS's proposed payment for interprofessional consultations performed via communications technology such as telephone or internet (CPT Codes 994X6, 994X0, 99446, 99447, 99448, and 99449).**

Proposals: CMS proposes separate payment for CPT codes 994X6, 994X0, 99446, 99447, 99448, and 99449. CMS is proposing to require the treating practitioner to obtain verbal beneficiary consent in advance of these services, which would be documented by the treating practitioner in the medical record, like the conditions of payment associated with the care management services under the MPFS.

Comments: We support CMS's proposed payment for interprofessional consultations performed via communications technology such as telephone or internet (CPT Codes 994X6, 994X0, 99446, 99447, 99448, and 99449). NAACOS is pleased to see CMS recognize that such care coordination services can be facilitated via phone, internet, or electronic health record technology. ACOs rely on such consultative services as a critical care coordination tool, particularly for complex patients managing multiple, chronic conditions. We urge CMS to avoid creating burdensome billing requirements that are a barrier to using such services.

Telehealth Services

Key Comments:

- **NAACOS supports proposals to allow clinical assessments via telehealth for certain ESRD-related care;**
- **NAACOS supports CMS's proposal to remove restrictions on geographic locations and types of originating sites where acute stroke telehealth services can be furnished; and**
- **NAACOS supports CMS's proposal to add codes G0513 and G0514 to the approved Medicare telehealth list for 2019.**

Proposals: CMS proposes the addition of two new codes to describe additional consultative services, interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional (994X0) and interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional (994X6).

Per the Bipartisan Budget Act of 2018 (BBA), CMS proposes to allow an individual determined to have end-stage renal disease receiving home dialysis to choose to receive certain monthly end-stage renal disease-related (ESRD-related) clinical assessments via telehealth. CMS also proposes to remove the restrictions on the geographic locations and the types of originating sites where acute stroke telehealth services can be furnished.

Finally, CMS proposes to add the following services to the Calendar Year 2019 telehealth list: Prolonged preventive services requiring direct patient contact beyond the usual service in the first 30 minutes (GO513); and each additional 30 minutes (G0514).

Comments: NAACOS supports the CMS proposals to allow an individual determined to have end-stage renal disease receiving home dialysis to choose to receive certain monthly end-stage renal disease-related (ESRD-related) clinical assessments via telehealth and remove the restrictions on the geographic locations and the types of originating sites where acute stroke telehealth services can be furnished. Finally, NAACOS also supports CMS's proposal to add codes G0513 and G0514 to the approved Medicare telehealth list for 2019.

Part B Drug Payment

Key Comment: NAACOS urges CMS not to finalize proposals to reduce Medicare reimbursement for new drugs from Wholesale Acquisition Cost (WAC) plus 6 percent to WAC plus 3 percent.

Proposals: While the majority of Part B drugs are paid at ASP plus 6 percent, certain drugs — including new drugs in the ASP reporting lag — -are currently paid at the WAC plus 6 percent. MedPAC has recently stated that WAC pricing is not reflective of actual prices paid in the market because WAC does not include discounts and that a shift in payment to WAC plus 3 percent would bring greater parity with ASP-based costs. CMS is proposing to reduce the add-on payments from WAC plus 6 percent to WAC plus 3 percent for drugs and biologic products that are produced or distributed under an NDA approved by the Food and Drug Administration (FDA) and that are not included in the Average Sales Price (ASP) Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File.

Comments: Implementing this reduction in reimbursement for new drugs would restrict patient access to new treatments and therapies that may be more effective than existing drugs and would increase costs by pushing such patients to a more expensive site of service, for example, a facility where a payment would be provided to both the physician as well as a facility fee. CMS should encourage the right care at the right place of service. Restricting access to physician-administered drugs will restrict a patient's choice while increasing costs for the patient and health care system.

Request for Information on Promoting Interoperability

> **Key Comment: NAACOS urges CMS to require the sharing of Admissions, Discharge and Transfer (ADT) information as a Condition of Participation in Medicare to further facilitate care coordination activities.**

Request for Information: CMS seeks stakeholder feedback regarding ways the administration could further facilitate value-based care and care coordination activities through improved interoperability.

Comments: While both adoption of Electronic Health Records (EHRs) and electronic exchange of information have grown substantially among hospitals, significant obstacles to exchanging electronic health information across the continuum of care persist and, in some cases, routine electronic transfer of information post-discharge has not been achieved by providers and suppliers in many localities and regions throughout the nation. For this reason, the ACO may not have access to complete information about all of the clinical information and services that are provided to its assigned beneficiaries by providers outside the ACO, creating a significant challenge to the ACO's care coordination efforts. A critical factor in an ACO's success at providing high quality care while lowering costs is the sharing of data across the ACO's providers and care settings. This often requires the ACO to gather information from payers, health systems, labs, pharmacies and other sources, but it still may leave the ACO without a complete picture. Our comments below reflect ACOs' desire to make patient health information fully transparent and available to the entire care delivery team.

ACOs aim to provide coordinated care to ensure that patients get the right care at the right time and avoid unnecessary duplication of services. In order to provide highly coordinated care, ACOs need critical information about a patient's admission to and discharge from a hospital. To improve interoperability to further facilitate this critical care coordination, NAACOS recommends that Emergency Department (ED) visit and admission information, as well as transfer and discharge information is shared at a minimum as a requirement of CMS health and safety standards for providers and suppliers participating in the Medicare and Medicaid programs (the Conditions of Participation (CoPs), Conditions for Coverage (CfCs), and Requirements for Participation in Medicare. Specifically, we recommend the following:

1. CMS should adopt the following standards requiring hospitals to release ADT data:
    - Presentation in Emergency Room/Admissions: The hospital must send real-time electronic notification that a patient has presented in the emergency room and/or been admitted to practitioner(s) responsible for the admitted patient's care.
    - Discharge to Home: The hospital must send real-time electronic notification of discharge to practitioner(s) responsible for the discharged patient's care. The hospital must also electronically send a copy of the discharge instructions and the discharge summary within 48 hours of the patient's discharge.

- Transfer of Patients to Another Health Care Facility: The hospital must send necessary medical information to the receiving facility at the time of transfer and must send a real- time electronic notification of the transfer to the practitioner(s) responsible for the transferred patient's care.

2. CMS should allow hospitals to meet these conditions over time (for example, by phasing in notification for greater numbers of patients over time) using existing health information exchange networks, private sector partners, or direct connections to community practitioners**.** Such an approach gives hospitals and community practitioners time to develop the processes and infrastructure necessary to meet such a requirement. Existing community networks are preferred where available.
3. CMS should require hospitals to make certain information electronically available to patients within 24 hours, such as discharge instructions and a summary of care, and through a designated third-party tool of their choice if desired.

Providing this admission, discharge and transfer information makes much-needed structured data about a patient's health transparent to the entire care delivery team and allows care teams to monitor patients' health and connect with them proactively. Informing providers about key encounters like hospitalizations and emergency department visits allows the care team to follow-up with discharge instructions and ensure a more effective transition of care. Taking this unprecedented step will allow for ACOs to more effectively monitor the health of the patients they serve, and we fully support these changes. Additionally, CMS should as a first step, provide The Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) feeds to ACOs while more direct interoperability standards are set. The HETS data are very meaningful and should be provided in real time to ACOs for their beneficiaries. This would allow ACO providers to communicate with treating providers at the hospital and to work with the beneficiary upon his or her release to ensure optimal treatment, medication adherence and follow up care. Providing ACOs access to this critical information in real time will allow ACOs to further enhance care coordination, improve outcomes and reduce costs.

HIPAA Privacy, Security, and Breach Notification Rules were designed to protect the privacy and security of patient health information. The HIPAA rules are flexible and scalable to accommodate the broad range in types and sizes of entities that must comply with them. This means that there is no single standardized program that could appropriately train employees of all entities. Due to this complexity, there is currently a large amount of misinformation and misunderstanding around these requirements and what the law truly allows in terms of sharing patient information. Therefore, we also recommend that the Department of Health and Human Services (HHS) conduct a broad education campaign to increase understanding regarding HIPAA and what this law currently allows for sharing of patient health information for treatment, payment and health care operations. Providing clear and concise education to the provider community would eliminate confusion that currently may act as a barrier to sharing of patient health information for treatment purposes while providing clinicians and health care teams with greater confidence in their ability to share certain health information.

QUALITY PAYMENT PROGRAM (QPP) PROPOSALS

Advanced APM Proposals and Recommendations

Advanced APM Participation

> **Key comment: Address CMS's projected decrease in the number of Qualifying APM Participants (QPs) in PY 2019 by promoting policies that support ACO growth and increased participation**

Proposals: CMS estimates the number of providers qualifying for Advanced Alternative Payment Model (APM) bonuses will decrease in the third year of the program, which includes the PY 2019 and 2021 payment adjustments. Specifically, the agency estimates that between 160,000 and 215,000 clinicians will become QPs and earn bonuses. This projection is lower than CMS's estimate for the PY 2018, which is between 180,000 and 245,000 QPs.

Comments: NAACOS is very troubled by the projected decrease in the number of QPs in the third year of the QPP. Today, health care in the United States is too expensive and quality is inconsistent. We need to continue moving away from siloed fee-for-service (FFS) payment toward a system focused on value. The Medicare ACO program, including the Medicare Shared Savings Program (MSSP) and the Next Generation ACO Model, has grown to more than 600 ACOs covering 12 million Medicare beneficiaries and including more than 300,000 providers. It is the largest value-based payment effort in the United States and an essential tool in moving the health system toward better value. Unfortunately, in a recently released Notice of Proposed Rulemaking (NPRM), titled *Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations — Pathways to Success,* CMS predicts its proposals will result in 109 fewer ACOs in the future. This decrease is troubling and limits opportunities for providers to participate in Alternative Payment Models (APMs) under MACRA. If finalized, program changes such as reduced shared savings rates and significant restrictions on how long new ACOs can participate in shared savings only opportunities would deter new entrants. Shutting off a pipeline of beginner ACOs is very troubling as these are the very organizations that should be encouraged to embark on the journey to value, which is a long-standing bipartisan goal of the administration and Congress, a critical aspect of the QPP, as well as a goal of ACOs and many in the broader healthcare industry. NAACOS looks forward to submitting more detailed comments in response to the MSSP NPRM, focusing on positive proposals in the rule as well as challenges such as those noted above. It is imperative that CMS consider the connection between the MSSP NPRM and growth of providers in APMs under MACRA.

Financial Risk Requirements

> **Key comments: NAACOS urges CMS to maintain the 8 percent revenue-based nominal amount standard for future years and to remove Part A revenue from the calculation. We also request CMS revise current policies to lower the benchmark-based nominal amount standard to 1 percent and to account for ACO investments in risk calculations.**

Proposals: CMS proposes to maintain the revenue-based standard at 8 percent for PY 2021 through 2024; no changes are proposed to the benchmark-based standard. CMS seeks feedback on whether the agency should raise these levels in 2025 and later.

Comments: In the MACRA statute, Congress provided for steep increases in financial risk requirements for Advanced APMs by increasing the percentage of participants' revenues that must come through the APM in order for participants to attain QP status. An APM Entity that is accountable for losses of up to 8 percent of 50 percent of its Medicare revenue in the 2019 performance period is clearly accountable for significantly steeper financial losses than in the 2017 and 2018 performance periods, when a minimum of 8 percent of 25 percent of its Medicare revenue would be at stake. Furthermore, Congress intended for the six-year period from 2019 through 2024 to be a period of stability, with the time-limited payments helping to offset transformation costs that APM Entities incur as they transition to APMs. Therefore, it is highly appropriate for CMS to maintain the 8 percent revenue-based standard for PY 2021 through 2024, and we urge CMS to finalize this proposal. We also urge the agency to maintain the 8 percent revenue-based standard in 2025 and beyond and use positive incentives to attract providers to APMs with risk levels that are potentially higher than the minimum threshold.

While we strongly support a revenue-based risk threshold, we urge CMS to focus the revenue-based threshold exclusively on Part B revenue and remove Part A revenue. CMS's current policy sets the Advanced APM revenue-based threshold at 8 percent of an APM Entity's Medicare Part A and B revenue. By including Part A revenue, CMS significantly disadvantages APM Entity's such as ACOs that have hospital participants. Their Part A revenue comprises all revenue for the hospital, including that which is for patients outside of the ACO model. In certain instances, only a small portion of the hospital's Part A revenue may be related to attributed beneficiaries under the ACO. Therefore, the loss sharing limit for the ACO would be based largely on Part A revenue for patients outside the ACO, thus penalizing ACOs with hospital participants by significantly raising their loss sharing limit. We recommend CMS fully analyze the impact of including Part A revenue and publicly release data and analysis on how this would affect different types of ACOs, such as those with hospitals, versus those without hospital participants.

The Advanced APM bonus is based on payments for covered professional services under the Medicare Physician Fee Schedule, and we strongly recommend CMS establish a revenue-based threshold that also focuses solely on revenue under the Medicare Physician Fee Schedule. Not doing so creates an asymmetry between the risk level and Advanced APM payments and could create an unintended consequence of ACOs dropping hospitals as ACO participants. This would harm efforts to enhance care coordination across delivery settings and could diminish opportunities to reduce hospital spending, which is one of the greatest areas for potential savings. We urge CMS to modify the 8 percent revenue-based threshold by removing Part A revenue and only include an APM Entity's Part B revenue. We also urge CMS to lower the 3 percent benchmark-based standard to a more appropriate threshold of 1 percent. Using 4 percent of total Medicare Parts A and B expenditures for the benchmark-based standard is far more than "nominal risk as required under MACRA." In fact, the Regulatory Impact Analysis of the 2017 QPP rule notes that CMS has long defined "significant" impact as 3 percent of physician revenue. We urge CMS to revise the benchmark-based threshold by lowering it to 1 percent.

As previously advocated by NAACOS, we also urge CMS to account for the significant investments ACOs make in start-up and ongoing costs and include these costs as part of the definition and calculation of risk. We oppose the CMS policy that disregards these investments by not including them as part of the definition and calculation of risk. We disagree with CMS's assertion that the agency couldn't objectively and accurately assess business risk without exceptional administrative burden on both CMS and APM Entities to quantify and verify such expenditures. If CMS carefully defined simple, clear standards for business risk and required documentation and attestation from ACOs, the agency could

surely create a method to account for these investments. We also disagree with CMS's claim that business risk is not analogous to performance risk. Both require significant investments from providers and put them at jeopardy of financial losses and should therefore be considered risk. We request the agency implement a process for accounting for these significant investments beginning with the 2019 QPP performance period.

Use of Certified Electronic Health Record Technology (CEHRT)

> **Key comment: NAACOS opposes increasing the Advanced APM CEHRT requirement from 50 to 75 percent and urges CMS to not finalize this proposal.**

Proposals: Current policy requires that an Advanced APM must require at least 50 percent of ECs in each APM Entity to use CEHRT to document and communicate clinical care with patients and other health care professionals. CMS proposes to increase the threshold to 75 percent beginning with PY 2019.

Comments: NAACOS opposes increasing the Advanced APM CEHRT requirement from 50 to 75 percent and urges CMS not to finalize this proposal. While notable progress has been made with EHR implementation and use, the proposed increase is too great and too early. It is an especially challenging time considering the mandated upgrade from 2014 edition CEHRT to 2015 edition CEHRT, which is discussed further in this letter. We recommend CMS not increase the Advanced APM CEHRT requirement at this time.

QP and Partial QP Determinations

> **Key comment: NAACOS requests CMS finalize policies for QP determinations to provide more timely, detailed information about QP determinations.**

Proposals: CMS proposes to shorten the claims run-out timeframe for data used to make QP determinations from 90 days to 60 days. This would apply to each of the three QP determination snapshot dates (March 31, June 30, and August 31) allowing QP determinations to be made more quickly, approximately three months after the snapshot date. If finalized, this would alter the timeframe in which claims need to be processed in order for those services to be included in calculating the QP threshold score. CMS proposes to align the MIPS election policy across Partial QP APM Entities and ECs by requiring Partial QP ECs to make an election that they want to report MIPS and be subject to payment adjustments. As with Partial QP APM Entities, no election by the EC means they would be exempt from MIPS.

Comments: As noted in the proposed rule, based on CMS's analysis of Medicare Part B claims for 2014, the agency found that there is only a 0.5 percent difference in claims processing completeness when using 60 days rather than 90 days. Given the minimal difference and the need to provide QP determination sooner, we support this proposal and request it be finalized. It is essential that ACOs and other APM Entities have information about their QP results as quickly as possible so that they can determine appropriate steps should they fall short of the thresholds, which will rise in PY 2019 and again in PY 2021. As part of the QP results, we urge CMS to provide more detailed information about where ACOs fall relative to the QP thresholds and to further break this information down by the TINs or NPIs that comprise the ACO. This level of detail is very insightful as ACOs plan for the future and should be provided to all ACOs. We also support aligning the Partial QP MIPS election policy across APM Entities and ECs to avoid confusion.

All-Payer Combination Option

CEHRT Use Requirements

Key comments:

- **NAACOS opposes increasing the All-Payer Combination Option Advanced APM CEHRT requirement from 50 to 75 percent and urges CMS not to finalize this proposal.**
- **NAACOS supports CMS allowing flexibility for how providers and payers demonstrate CEHRT use with Other Payers and permitting documentation about such use rather than requiring specific contract language.**

Proposals: CMS proposes to increase the Other Payer Advanced APM CEHRT use requirement from 50 percent to 75 percent beginning with PY 2020. Therefore, if finalized, as of January 1, 2020, the Other Payer APM arrangement must require at least 75 percent of participating ECs in each APM Entity to use CEHRT. CMS also proposes to modify the nature by which Other Payer APMs demonstrate they meet the CEHRT use requirements. Specifically, the agency proposes that a payer or EC must provide documentation to CMS that CEHRT is used to document and communicate clinical care under the payment arrangement by at least 50 percent of the ECs in PY 2019 and 75 percent of the ECs in PY 2020 and beyond.

Comments: NAACOS opposes increasing the Other Payer Advanced APM CEHRT use requirement from 50 to 75 percent and urges CMS not to finalize this proposal. While notable progress has been made with EHR implementation and use, the proposed increase is too great and too early. The All-Payer Combination Option begins in performance year 2019, and it is premature to increase thresholds, even if that increase would not go into effect until 2020. Therefore, we recommend CMS not increase the All-Payer Combination Option Advanced APM CEHRT use requirement.

MACRA requires that Other Payer APMs show that CEHRT is used, and CMS previously enforced this by necessitating payers or providers demonstrate that CEHRT is explicitly required in the terms of the payment arrangement. However, given concerns that many contracts do not include such explicit language, we fully support CMS's proposal that a payer or provider could provide documentation to CMS, but not specific contract language, that CEHRT is used to document and communicate clinical care under the payment arrangement by the required proportion of ECs in a specific performance year. We appreciate CMS proposing this flexibility which balances the statutory requirement with the real-world scenarios and agreements between payers and providers, and we urge CMS to finalize this proposal.

Financial Risk Requirements and Determining Other Payer APMs

Key comments:

- **NAACOS supports CMS's proposal to maintain the 8 percent Other Payer revenue-based nominal amount standard and urges the agency to focus this threshold only on physician revenue.**
- **NAACOS strongly recommends that CMS align standards for Medicare and Other Payer APMs and not require higher or more complicated risk levels for Other Payer APMs to qualify as Advanced APMs.**

Proposals: CMS proposes to maintain the 8 percent revenue-based nominal amount standard for Other Payer Advanced APMs through 2024. The agency also proposes that after the first year a requestor (i.e., payer, APM Entity or EC) submits information about a multi-year payment arrangement that is determined to qualify as an Other Payer Advanced APM, in subsequent years the requestor would only need to submit information on any relevant changes to the payment arrangement. For multi-year payment arrangements submissions, CMS proposes to require that the requestor's certifying official agree to review the submission at least annually to assess whether there have been any changes and to submit updated information notifying CMS of any changes relevant to the Other Payer Advanced APM criteria for each successive year of the arrangement.

Comments: We fully support the proposal to maintain the 8 percent revenue-based nominal amount standard for Other Payer APMs and urge CMS to finalize this proposal. As noted in our comments on the Medicare nominal amount standard, the increasing QP thresholds inherently necessitate increased risk on behalf of APM Entities and as such CMS should not raise the nominal amount standard in future years. While updating the Other Payer nominal risk standard to maintain the 8 percent revenue-based standard, we urge CMS to focus this threshold only on physician revenue and to lower the required Other Payer benchmark-based standard from 4 percent to 1 percent, or at least to the level set for Medicare APMs, which is currently 3 percent.

We also request that CMS revise previously finalized requirements related to 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 did not finalize proposed 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, research on physician participation in new payment models has found that the need to manage multiple and conflicting requirements from different payers is a strong disincentive to broader participation in these models and can also 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.

We are very pleased with CMS's proposal to provide flexibility related to submission of information and determination of whether an Other Payer APM qualifies as Advanced. We have previously raised concerns about the onerous nature of these requirements and appreciate CMS proposing to streamline this process so that after the first year a requestor submits information about a multi-year

payment arrangement, which is determined to qualify as an Other Payer Advanced APM, in subsequent years the requestor would only need to submit information on any relevant changes to the payment arrangement. We urge CMS to finalize this proposal. We understand CMS's need to have requestors annually review information to assess whether material changes have been made and submit updated information and support CMS's proposed process for doing so. We support the proposal that absent a submission of updated information CMS would continue to apply the original Other Payer Advanced APM determination until the arrangement ends or expires or it has been five years since the determination was made. If finalized, these proposals would help simplify the burdensome process for attaining QP status under the All-Payer Combination Option, and we urge CMS to further simplify this process so that it is fully utilized by those participating in qualifying Other Payer APMs.

Other Payer QP Calculation

Key comment: NAACOS supports providing flexibility to allow Other Payer QP determinations and applying the most advantageous score.

Proposals: CMS proposes an option for a Tax Identification Number (TIN) level Other Payer QP determination, which if finalized, would be available in instances where all clinicians who have reassigned billing rights under the TIN participate in a single APM Entity, meaning it would be an option for MSSP ACOs. Should the TIN-level Medicare QP score be lower when based on the TIN-level calculation as opposed to the APM Entity calculation, CMS proposes to apply the higher score. If requests at multiple levels (i.e., EC, TIN or APM Entity) are received by CMS, the agency would calculate all requests and apply the most advantageous determination.

Comments: We support CMS's proposal to introduce a TIN-level Other Payer QP determination and to apply the most advantageous result (e.g., Eligible Clinician-, TIN- or APM Entity-level) in instances where multiple requests are received. These has been confusion around how CMS would handle APM Entity requests when there is not full overlap in APM Entity participation with Medicare APMs and Other Payer APMs, which is not uncommon. These proposals would help address some of these concerns and we request CMS finalize them.

Medicare Advantage (MA) Qualifying Payment Arrangement Incentive

Key comment: NAACOS supports CMS moving forward with implementation of the MAQI demonstration.

Proposals: CMS includes proposals to implement the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI). Specifically, the agency proposes this demonstration would allow participating Eligible Clinicians (ECs), who are not QPs or Partial QPs but who meet certain criteria related to the demonstration, to be exempt from MIPS reporting and payment adjustments. For purposes of the demonstration, CMS would apply requirements for Qualifying Payment Arrangements consistently with the criteria for Other Payer Advanced APMs. CMS proposes the thresholds for Medicare payments or patients through Qualifying Payment Arrangements with MA organizations, which must be met to attain a MIPS waiver, and those thresholds are proposed to be set at 25 percent for payments and 20 percent for patient count. CMS proposes to begin the MAQI demonstration in 2018 and run it for five years.

Comments: We support implementing the MAQI demonstration and were pleased to see initial mention of this in the final 2018 QPP rule. At that time, CMS noted plans to implement this in 2018, but it is unclear how the agency will accomplish full implementation in the last quarter of 2018 given the late start of the program and remaining uncertainties around participation. The proposed 25 percent payment and 20 percent patient thresholds are reasonable and should be finalized. We encourage CMS to reconsider how participants of this demonstration could qualify for Advanced APM bonuses through the demonstration in addition to being exempt from MIPS reporting and payment adjustment requirements.

Merit-Based Incentive Payment System (MIPS) Proposals and Recommendations

MIPS Performance Thresholds and Exclusion Criteria

Key Comments:

- **NAACOS supports CMS's proposals to raise the MIPS performance and exceptional performance thresholds.**
- **We urge CMS to hold clinicians accountable in the MIPS program and reward high-performing clinicians, who have invested heavily in performance improvement, by reducing the number of clinicians exempted from MIPS program criteria.**

Proposals: CMS proposes to increase the MIPS performance threshold from 15 points (for 2018) to 30 points in 2019. This means an EC must meet or exceed 30 points in MIPS to avoid penalties in the program. CMS also proposes to increase the exceptional performance threshold from 70 points (for 2018) to 80 points in 2019. Additional bonus opportunities are available to those that meet or exceed the exceptional performance threshold. MACRA originally required CMS to increase the MIPS performance threshold to either the mean or median performance beginning with the 2019 performance year, however the Bipartisan Budget Act of 2018 afforded the agency with additional flexibility in raising the performance threshold over time to provide clinicians with an additional three years to transition to use of mean/median performance as the established threshold in MIPS.

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 30 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.

Assigning Quality Points Based on Benchmarks

> **Key Comment: NAACOS urges CMS to adopt an alternative methodology for making quality comparisons in MIPS to create more equitable benchmarks across reporting mechanisms.**

Proposals: CMS seeks comments on its proposal to separate benchmarks for the following submission mechanisms: EHR, Qualified Clinical Data Registry/registry, Web Interface, CMS-approved vendor, and administrative claims. In the proposed rule, CMS states it would apply benchmarks based on collection type rather than submission mechanism.

Comments: Given the broad changes to the definitions of different options that can be used for submitting data for MIPS performance measures and activities, it is unclear whether the proposed changes would result in a change in how CMS currently develops quality benchmarks in MIPS. 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 Group Practice Reporting Option (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 nonsensical 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 (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 Promoting Interoperability performance category, creates confusion and perceived instability in the program.

Assigning Quality Bonus Points in MIPS

> **Key Comment: NAACOS urges CMS to rescind its proposal to eliminate quality bonus points for ACOs while awarding automatic quality bonus points for small practices.**

Proposals: CMS proposes to no longer award bonus points to those reporting via Web Interface. Previously, CMS has provided ACOs with bonus points for reporting Web Interface measures

categorized as "high priority" by MIPS. Beginning in 2019, CMS proposes to no longer award ACOs with these bonus points. CMS also notes it may remove bonus opportunities for high priority measures altogether in future program years. CMS does not propose to eliminate bonus points awarded to those who report quality using end-to-end electronic reporting. At the same time, CMS also proposes to award small practices with automatic quality bonus points simply for being designated a small practice.

Comments: ACOs are currently awarded bonus points, subject to a maximum, for reporting on certain quality measures designated as high priority and outcomes measures in MIPS. CMS's proposal to no longer award such bonus points to ACOs is arbitrary and reflects an unfair comparison between ACOs and non-ACOs in MIPS. ACOs have demonstrated high quality in both the MSSP and Next Generation ACO programs. Additionally, recently released 2017 MIPS performance results indicate high quality performance among ACOs. Punishing the very organizations who have demonstrated a high commitment to quality is discouraging and demonstrates an unfair assessment by CMS which is also evident in the way that the agency currently creates quality measure benchmarks (see above). Further, to simultaneously propose to award quality bonus points automatically to small practices for no other reason than the number of clinicians in the group demonstrates that ACOs are being held to unfair quality comparisons in MIPS despite their outstanding performance. The agency notes that in the future it may consider removing all bonus point opportunities; until and unless that is proposed, CMS should not hold ACOs to unfair comparisons by eliminating quality bonus points simply because the measures were submitted by an ACO on behalf of its clinicians.

Promoting Interoperability (PI) Requirements for ACOs

Key Comments:

- **NAACOS supports CMS's proposal to allow clinicians in ACOs to report PI measures either as an individual or as a group (Tax Identification Number) and urges CMS to also provide ACOs with additional flexibility in reporting PI performance category criteria.**
- **NAACOS stresses the importance that CMS prioritize education among staff and contractors of the nuances that apply to ACOs and practices/clinicians in ACOs for the PI performance category.**
- **NAACOS urges CMS not to finalize proposed changes to the structure of the PI performance category scoring method.**
- **NAACOS requests hardship options and/or fallback policies for organizations negatively impacted by vendor issues that may arise preventing a successful transition to 2015 Certified EHR Technology (CEHRT).**
- **NAACOS requests CMS provide additional information regarding how ACOs subject to MIPS will be affected by other CMS proposals to remove ACO quality measure 11, Use of CEHRT.**

Proposals: CMS proposes a number of significant changes to the Advancing Care Information performance category, which has been re-named the Promoting Interoperability (PI) performance category. Notably, CMS does not propose to delay the requirement to move to 2015 Certified EHR Technology (CEHRT) beginning in 2019. This affects all ACOs who must report ACO quality measure 11, Use of CEHRT, which is based on MIPS PI requirements. CMS also proposes significant changes to the way the category is structured and scored, removing the Base and Performance components of the

score for this category to move to more "performance-based measurement." Beginning in 2019, CMS also proposes to allow clinicians in ACOs to report PI measures either as an individual or as a group (TIN). Finally, CMS also proposes to provide a zero PI score for Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, and Physical Therapists, Occupational Therapists, Clinical Social Workers and Clinical Psychologists for 2019.

CMS also proposes including certain new measures related to opioid use, added to the e-prescribing measure, Query Prescription Drug Monitoring Database (PDMP) and Verify Opioid Treatment Plan. CMS proposes these measures would be optional in 2019 and required beginning in 2020.

Comments: NAACOS supports CMS's proposal to allow clinicians in ACOs to report PI measures either as an individual or as a group (TIN). However, we urge CMS to provide ACOs with additional flexibility in reporting PI performance category criteria by allowing an option in which the ACO entity could report PI on behalf of its clinicians if it chooses to do so. Reporting and keeping track of performance in this category has been a great challenge for ACOs given the conflicting information that continues to be provided to ACOs and the clinicians in ACOs in regard to the PI performance category. Certain educational efforts by CMS and its contractors have resulted in misinformation being provided to practices and clinicians in ACOs which results in an enormous amount of confusion. We urge CMS to prioritize educating staff and contractors of PI criteria, particularly those involved in outreach and education, regarding the important differences in requirements for clinicians and practices in an ACO. With more than 300,000 providers in ACOs, it is imperative that ACO-specific education be provided. Unfortunately, misinformation continues to be a widespread problem and one that CMS staff have noted on public forum calls. NAACOS would be pleased to provide support in any way we can be helpful to ensure communications from the agency are clear to ACOs and the clinicians that practice in such organizations.

NAACOS urges CMS not to finalize proposed changes to the structure of the Promoting Interoperability performance category scoring method. The proposals the agency details are significant and come on the heels of many other program changes such as the transition to MIPS in general as well as the move from Meaningful Use to Advancing Care Information (now Promoting Interoperability). Such changes are disruptive and should be avoided, particularly if they do not add value or reduce burdens significantly.

While many ACOs have been steadfastly preparing for the eventual move to 2015 CEHRT, often there are times when vendor issues which are outside the organization's control may cause significant delays or other implementation problems that are unforeseen. In these cases, CMS must provide hardship options and/or fallback policies for organizations negatively impacted by vendor issues that may arise preventing a successful transition to 2015 CEHRT despite the best intentions.

Additionally, in the recently released proposed rule, "Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success," CMS proposes to eliminate the ACO quality measure 11, which evaluates an ACOs use of CEHRT. Neither the MPFS proposed rule nor the Pathways to Success rule clearly specify how ACOs subject to MIPS would be affected by this proposal. NAACOS requests CMS provide additional information regarding how ACOs will demonstrate 2015 CEHRT use if proposals are finalized to eliminate ACO quality measure 11. Specifically, we urge CMS to not require ACOs subject to MIPS to continue to be subject to the PI category and provide additional

information regarding how the remaining performance categories would be scored under the MIPS APM evaluation. NAACOS urges CMS to redistribute the PI category weights equally to the Quality and Clinical Practice Improvement Activities performance categories (15 percent added to Quality, 15 percent added to Improvement Activities). This would result in ACOs being evaluated in MIPS as MIPS APMs as follows: Quality 65 percent; Improvement Activities 35 percent; Cost 0 percent; Promoting Interoperability 0 percent.

Finally, NAACOS supports CMS's efforts to incorporate quality measures related to opioid use. ACOs remain committed to combatting the opioid epidemic and support efforts to include quality measures to further emphasize quality improvement activities in this area. However, given the operational complexity associated with such measures, we urge CMS to refrain from making such measure mandatory in 2020 as clinicians will need additional time to implement new work flows and make adjustments in the EHR to capture the appropriate data for such measures. For example, for the Query PDMP measure, clinician workflows will need to be updated to capture new documentation and new fields may need to be added to EHRs by vendors so that the query that was performed is can be documented and reported.

MIPS Performance Results

Key Comments:

- **NAACOS urges CMS to provide ACOs with more detailed and transparent performance information for MIPS.**
- **NAACOS recommends that CMS conduct an analysis comparing ACO quality to non-ACO quality in MIPS.**

Proposals: CMS does not indicate changes in ways the agency will communicate MIPS performance results to ACOs. CMS does propose to include additional MIPS performance information on the Physician Compare website in future years. CMS proposes it will publicly report the MIPS final score on Physician Compare, as well as performance for each category and periodically, aggregate MIPS information, for each MIPS-eligible clinician. CMS plans to report individual, group-level, and QCDR measures starting with 2016 data. CMS states it will use statistical testing and website user testing to determine how and where measures are reported on Physician Compare. Specifically, CMS plans to report clinicians' performance on each MIPS performance category as well as list the names of clinicians in Advanced APMs and the type of APM the clinician participated in.

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 Promoting Interoperability performance category. These concerns have been raised by ACOs and NAACOS to CMS; however, to date, the agency has not acknowledged a widespread issue with how 2017 Promoting Interoperability scores were calculated for ACOs. NAACOS believes there are extensive issues with how CMS has calculated 2017 Promoting Interoperability performance scores for ACOs. These ACOs have been told to request a Targeted Review in order to be able to receive transparent information regarding how CMS has calculated such scores. This process will take a great amount of staff time and resources to complete, and we urge CMS to swiftly address

these issues and, if necessary, provide updated and correct 2017 Promoting Interoperability performance scores for ACOs. Further, 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. For example, Promoting Interoperability performance scores should clearly explain how group-level (or in the future, individual-level) performance contributed to the ACO entity's overall score in this category.

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

> **Key Comment: NAACOS urges CMS to exclude MIPS payment adjustments as ACO expenditures.**

Proposals: CMS proposes that the agency would not apply MIPS adjustments to certain model-specific payments for the duration of an 1115 A model testing, beginning in 2019 such as Oncology Care Model per member per month payments. However, CMS does not propose to change its current policy that unfairly treats 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. However, because CMS continues to subject Track 1 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 under the 2017 MIPS performance criteria to earn exceptional performance bonuses under the program. While aggregate program data has not yet been made available by CMS, many ACOs have already reported perfect or nearly perfect scores in MIPS for 2017. These bonuses will then count against the ACO when expenditures are calculated for purposes of MSSP calculations. Therefore, the better an ACO and its ECs 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. 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. Further, in this proposed rule CMS proposes that the agency would not apply MIPS adjustments to certain model-specific payments for the duration of an 1115 A 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 Track 1 ACO Program.

Conclusion

We support many of the proposals in the proposed 2019 Medicare PFS and request that CMS considers our feedback related to these and other proposals for which we are requesting modification. ACOs play an integral role in moving the health system into a new era of high quality, integrated care designed to benefit patients, and reduce unnecessary costs and utilization. However, the ability of ACOs to succeed will depend largely on the policies CMS finalizes, and we urge the agency to consider the feedback presented from the ACO community outlined in this letter. Thank you for your consideration of our comments.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
National Association of ACOs