September 2, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on "Section M. Medicare Shared Savings Program," Within the Proposed 2015 Physician Fee Schedule Regulations

The National Association of ACOs appreciates CMS' effort to improve the Medicare Shared Savings Program (MSSP) and Pioneer ACO programs. We are thankful for your recognition of the burden the ACOs have in meeting program requirement and your efforts to reduce those. We also appreciate your willingness to listen and discuss the concerns of our member ACOs.

NAACOS is an organization of approximately 120 MSSP ACOs. We believe the fundamental goal of the ACO program is to both improve care quality and patient outcomes as well as lower Medicare cost growth. Our members experience to date has proven that achieving financial savings through clinical practice redesign is a difficult process that is both time intensive and costly. We have developed an even greater appreciation for the difficulty in successfully redesigning clinical care delivery to both improve care quality and collect and accurately report clinical data to satisfy the ACO programs quality performance benchmarks. Though there is no precise relationship between quality and price or quality and outcomes we remain fervently committed to improving patient and population outcomes and clinical cost efficiency.

After thorough review of CMS's proposed reforms to the ACO program's quality measures and performance benchmarking and after substantial communication with over 200 ACOs and NAACOS members we recommend CMS: (1) in the near term place a moratorium on adding additional measures to the quality measure set; (2) retire the proposed eight measures; (3) CMS participate with NAACOS, patient groups and other ACO stakeholders to identify a new measures set using outcome metrics that beneficiaries would understand best and deem worthwhile; (4) additionally, strengthen the incentives and rewards to improve quality by increasing the bonus points from two to four, allow ACOs to retain 50% of their share of savings regardless of the MSR if their overall quality score improves year-over-year, and award a 10% savings bonus to the top 10% quality ACOs; and lastly, (5) stabilize the quality benchmarks by updating the measure set and benchmarks no more frequently than every three years such that they would align with the three year contracting period. These recommended changes would enhance the ability of ACOs to improve care quality by improving the measures, incentives and rewards.

Provided below are detailed comments on CMS's proposal to add 13 new quality measures, delete eight and change the composition of the composite scores as well as other proposals. We also provide comments on the proposed chronic care management (CCM) fee, explaining at some length our belief that the proposed reimbursement is substantially inadequate.

Unfortunately, we find the vast majority of the proposed new measures to be unnecessary, inadequately defined, tested or benchmarked, methodologically unsound, beyond an ACO's control, requiring substantial change in clinical practice and/or substantially adding to the reporting burden or questionably related to improving care quality and/or patient outcomes. Concerning the seven areas proposed for future measures we believe most are premature, unnecessary or potentially measuring aspects of the care the Medicare program does not support. However, we do in theory propose measures in four other or un-recognized categories. We are generally in agreement regarding the expanded use of flat percentages, accelerating HIT use and the technical change to the second participation agreement. We believe "topped out" measures should remain in the measure set. We applaud CMS's recognizing year-over-year quality improvement by proposing to award two bonus points but believe the proposal does not go far enough and should be complimented with additional rewards for quality improvement.

12 Proposed New Quality Measures

We remain concerned about CMS's overall goals for the ACO program. Neither in the proposed 2015 rule nor in the final 2011 ACO implementation rule is the ACO program's overall goals measurably defined. In the 2011 final rule under "b. Considerations in Selecting Measures," CMS simply states the agency will "target conditions of high cost and high prevalence in the Medicare population" and will "reflect priorities of the National Quality Strategy." The final 2011 rule includes related language, for example, it states it is CMS's intent to adopt measures that focus on "patient experience, outcomes, and evidence-based care processes." CMS's six quality strategy goals are as well not measurably defined. The 2011 "National Quality Strategy" identifies non-specific "illustrative measures." While L&M Policy Research released last fall a report evaluating the extent to which the 32 Pioneer ACOs improved population health, care quality and controlled costs, how CMMI or L&M will evaluate more broadly the ACO program going forward is unknown. While we certainly agree ACOs should improve care quality and patient outcomes over time, or provide better care and better health at lower cost, it is difficult if not impossible to comment on the value or worth of the measure set, however modified or evolving, absent specific ACO program goals. As it stands today there appear to be no specific measures by which to assess or define the ACO program.

Instead of seemingly adding new measures indiscriminately we believe a more useful path would be to adopt MedPAC's recent recommendation that CMS move toward publicly reporting on "a small set of population-based outcome measures" concerning preventable hospital admissions and emergency department visits and condition specific mortality for ACOs as well as for MA and FFS Medicare. Richard Bankowitz and his colleagues drew a similar conclusion in Health Affairs in 2013 where they proposed a more parsimonious framework of health outcomes, patient experience and cost measures.

We believe CMS's proposed changes to the MSSP create several inherent problems. First, there are already simply too many measures in the program. We encourage CMS to compare the MSSP with the private sector's pay for performance initiatives. For example, the largest and longest running program, the California Pay for Performance Program run by the Integrated Health Association, with 200 physician organizations providing services to nine million patients, started in 2003 with 25 measures. In examining state approaches to aligning performance metrics among public and private payers Milbank recently found that Wisconsin condensed its initial set of 200 measures to 14 ambulatory and hospital-level measures.

Changing two-thirds of the quality measures is far too aggressive particularly for a large-scale program that has been in existence for little more than two years. While serving as AHRQ's

Director, Dr. Carolyn Clancy was famous for citing Balas, et al., that the adoption of clinical practice change takes, on average, 17 years. Consider too the modest success achieved by the Physician Group Practice demonstration, the model for the ACO program. As RTI concluded in its evaluation only one of the 10 large multi-specialty groups was truly successful. The Marshfield Clinic, year-over-year, earned half of the total performance payment awards. Consider too the findings by Lyle Nelson's CBO 2012 working paper concerning CMS's success since 2002 in improving disease management or care coordination services or reducing hospitalizations, i.e., ACO program goals. He concluded that, "on average, the 34 programs had no effect on hospital admissions or regular Medicare spending" that is "Medicare spending was either unchanged or increased in nearly all of the programs."

Substantially changing the measure set also creates even greater burden for ACOs. Aside from the additional administrative burden of retooling to extract and report new data, ACOs will be required to further reform their clinical practices. Beyond working to actually meet or achieve the quality measures, the proposed changes would make worse the apparent difficulty ACOs are having in accurately reporting their quality measurement data. As you are well aware Sherry Grund and her colleagues recently found 34 of 50 first and second year ACOs failed an audit measuring complete and accurate GPRO reporting. Again, substantial change in the measure set compromises a ACOs ability to achieve the quality improvement sought and reporting it accurately.

In sum, we believe the proposed substantial changes actually compromise an ACO's ability to innovate. As Everett Rogers noted in his seminal work "Diffusion of Innovation", "the innovation-decision process involves time in the sense that the five steps [in the innovation decision process] usually occur in a time-ordered sequence of (1) knowledge, (2) persuasion, (3) decision, (4) implementation, and (5) confirmation." Compromising time also leaves ACOs with fewer, what Rogers termed, slack resources, or as MedPAC noted the undue administrative burdensomeness of the measure set leaves providers with "fewer resources available for crafting their own ways to improve the outcomes of care." This is particularly problematic since CMS is not prescribing the change it seeks, just the outcome. Each ACO needs to invent clinical practice improvement. This is not an issue of diffusing a new technology nor can a new technology remedy what is a problem of adaptation or adapting new behaviors. On balance and again regardless of their merit, the proposed changes to the measure set would be far more disruptive than productive.

What follows are specific comments on the proposed new measures.

Measure #11: Particularly since this measure is doubly weighted, it is important to note there presently is no proven direct relationship between PCPs who successfully meet "meaningful use" requirements and improved quality of care. If this is a proxy measure for EHR use, still, the evidence is at least unclear. For example, a 2009 study published in the Journal of American Medical Informatics Association by Zhou, et al., concluded, "we found no association between duration of using an EHR and performance with respect to quality of care" and "for all 6 clinical conditions, there was no difference in performance between EHR users and non-users." A more recent and related 2013 RAND study concluded EHR technology "significantly worsened professional satisfaction" due to "poor EHR usability, time-consuming data entry, interference with face-to-face patient care, inefficient and less fulfilling work content, inability to exchange health information between EHR products and degradation of clinical documentation."

Measures #34 and #44: The CAHPS stewardship of resources (#34) and the CAD symptom management measure (#44) are unnecessary because ACO are naturally incented or intrinsically motivated to ensure patients practice medication adherence and a patient's angina symptoms are

well managed. The CAHPS stewardship measure asks "the patient whether the care team talked with the patient about prescription medicine costs." We are unclear what is meant by the measure exhibiting "high reliability." Moreover, presuming the measure is intended to examine the patient's ability to afford the cost of prescription drugs, what improved patient outcome or cost of care does CMS intend this measure to yield since generic drugs used by Medicare beneficiaries exceeded 75 percent in 2010 and today is assuredly higher.

Measure #35 and #40: We believe skilled nursing facility 30 day all cause readmission (#35) and depression remission at 12 months (#40) are unnecessary measures since again ACOs are inherently incented. Measure #35 would create an unlevel playing field measuring ACOs aligned with SNFs versus those unaligned. Is CMS's intention ACOs be measured for SNF-driven hospital readmissions independent of whether they are aligned with a SNF. Regardless, the measure does not "enhance" partnering, rather it coerces ACO - post acute care (PAC) partnerships that because of the high variation in SNF quality in many instances ACOs would be better off avoiding. We are also unclear what is meant by "ACO providers/suppliers furnish other services that have the potential to affect PAC outcomes."

While NAACOS members clearly understand and appreciate the fact depression compromises effective care delivery, our members nevertheless are particularly concerned about the depression remission (#40) measure for several reasons. First, this measure would involve substantial clinical redesign to capture PHQ 9 screening for all adults with a diagnosis of depression as well as involve implementing new infrastructure to re-assess at 12 months. Physicians should be judged on how well they treat patients according to standards therefore compliance with an appropriate therapy and/or medication is preferable over whether the patient is in remission or not. PHQ 2/9 is not discrete so in present format ACOs are unable to report, i.e., it would require initial manual chart review and eventually HIT redesign. The measure also assumes ACOs would have ready access to patient behavioral/mental health records. This is not the case. Federal regulation 42 CFR Part 2 ("Confidentiality of Alcohol and Drug Abuse Patient Records") has not been updated since 1987. As a result ACO access to these records is substantially compromised by the regulation since patients are required to provide each clinician written permission to view their records. Also, 42 CFR Part 2 in its current form provides no guidance on the use of electronic medical records. The inability of ACOs, HIEs and others to access and transmit these records is exactly why SAMHSA held a public hearing on potentially reforming or updating this regulation this past June 11th. Lastly, our rural members are particularly concerned measure #40 would discriminate against them because depression and other mental health disorders are substantially more prevalent in the communities they serve.

Measures #36-38: CMS notes that the proposed measures for all-cause admissions for patients with diabetes (#36), heart failure (#37), and multiple chronic conditions (#38) are "under development." While we highly respect Dr. Krumholz's work at Yale, it is impossible for any stakeholder to comment on measures that to date remain a fiction. Risk adjustment is begged and we question the value added worth of these measures since ACOs are again inherently incented to avoid or reduce hospital admissions.

Measures #41-42 and #43-45: These proposed measures for diabetic foot (#41) and eye exams (#42) and antiplatelet therapy (#43), symptom management (#44) and beta-blocker therapy (#45) for coronary artery disease patients are vague in that CMS does not note how they will be scored. Will these measures be scored as all or nothing. As these would be new composite measures, we note the following four issues CMS should address: 1) we believe new composites like existing composites should be review/approved by NQF; 2) it appears there is no evidence these two new composites are more effective than the existing composites; 3) combining measures developed by different organizations using different methodologies cannot be rationalized; and, 4) the proposed

new composites cannot be benchmarked. Additionally, our ACO members have noted the diabetic eye exam (#42) is traditionally performed by non-PCP specialists and they typically do not share their clinical records with a patient's PCP. Concerning beta-blocker therapy (#45) for LVEF, our ACOs have commented this measure will require manual chart review since LVEF is rarely placed in a discreet EHR field.

Eight Retiring Measures
We support CMS's proposal to retire the eight measures. In a poll of our members 71 percent either "strongly agreed" or "agreed" the measures should be retired.

Summary Comments On New Measures
Considering all the above concerns we believe CMS should place a moratorium on proposing new measures at least until the agency addresses two broader issues.

In its June report MedPAC states "over the past few years the Commission has become increasingly concerned that Medicare's current quality measurement approach has gone off the track . . . ." We agree with MedPAC's concerns that too many administratively burdensome measures leave less capacity for providers to create their own innovative ways to improve care. We believe the reality is less a matter of having "gone off the track" and more a matter of ACO providers not knowing what track the program is on. Confusion over expectations is the very definition of disappointment. As discussed above it would be useful to know more precisely and more measurably what are the strategic, not simply operational, goals of the ACO program. Again, we are thoroughly supportive of the triple aim principles, however, we would like to know what this means in practice.

We are hopeful the direction of the MSSP will be better defined by the changes in the still anticipated proposed rule to reform the ACO program more broadly. In this larger proposed rule we hope CMS addresses risk for second term ACOs, problems with beneficiary attribution or assignment, performance benchmarking, risk adjustment, the MSR, provider-patient communication and other issues. Absent comprehensive reform, we do not believe CMS is able to offer a justifiable or coherent vision of the quality measures going forward, nor is the ACO community truly able to comment adequately.

Minimum Reporting Requirement for PQRS Reporting
As noted on page 410 of the proposed rule, CMS proposes to reduce the GPRO web interface minimum reporting requirements for PQRS reporting from 411 to 248 consecutively ranked and assigned patients. Since 248 patients' meets standard or accepted confidence level and confidence intervals for 5,000 patients we support this proposed change. However, our larger ACO members have noted 248 may not adequately or accurately represent the diversity of their providers. Therefore, we propose ACOs have the option to report a larger patient sample size.

Future Quality Measures/Gaps in Measures
CMS proposes to develop additional measures for future rule-making in eight categories. These are: gaps in measures; caregiver experience of care; alignment with the value-based payment modifier; measures to access care in the frail elderly population; utilization; health outcomes; measurements for retirement; and, additional public health measures. We again stress CMS should evolve a more parsimonious list of measures that are increasingly outcome and population based. In theory we well recognize the value in particularly better recognizing and measuring the caregiver's experience of care, improving care for the frail elderly and additional public health or primary prevention measures. In practice however if CMS increases the measure set to 37 or grows the program at the rate of the Medicare in- and outpatient quality measures, ACOs will be reporting somewhere between 80 and 190 measures within the next seven to 10 years.

While we have specific comments on four of the seven categories identified above ("measures for retirement" are obviously not future measures), overall our members oppose measures, regardless of category, that measure utilization. We are surprised to see this issue identified since the proposed rule notes "intrinsic motivation," that is CMS repeats in the proposed its 2011 final rule comment that "the potential for shared savings will offer a sufficient incentive for ACOs to address utilization issues in a way that is most appropriate to their organization, patient population, and local healthcare environment."

We oppose applying the value-based modifier to ACOs beginning in 2017. Here, we are substantially in agreement with Berenson and Kaye's criticism published last November in NEJM. While the value based payment is "appropriate as a concept," the authors' state, applying it presently or in the near future constitutes "policy overreach" since CMS cannot now "accurately measure any physician's overall value." This is particularly the case in measuring primary care physician value since the authors' state further "a primary care physician currently reports on as few as three PQRS measures" while managing upwards of "400 different conditions per year". Also too, beyond overlap, CMS notes there are now two value-based measures already a part of the ACO measure set, we believe the "synergy" CMS seeks in theory between the two programs translates in practice to simply increasing ACO measurement burden and magnifying further their reimbursement risk. (We also encourage CMS to review the recently released and related report by the Center for Healthcare Quality and Payment Reform titled, "Measuring and Assigning Accountability for Healthcare Spending.")

"Gaps in measures" is defined as additional measures "to assess the ACO's performance with respect to care coordination in post-acute care and other settings." As we noted above, we believe measures of this sort are unnecessary since again ACOs are "intrinsically motivated" to better manage PAC and because the program does not currently require ACOs to contract with post-acute providers or providers in undefined "other settings."

We agree caregivers play an important role in ensuring optimal outcomes particularly for the frail elderly and/or those with functional limitations. However, effectuating care giver experience is not addressed in the Medicare program therefore we do not believe CMS should add future quality measures under this category.

In addition to supporting outcome and population-based measures, NAACOS members also agree, in principle, with measures that are within clear control of the ACOs, measures that attempt to insure there is no stinting of care, measures that encourage primary and secondary prevention since the health benefit from these services may not be realized for years; and, are better risk adjusted, for example, that account for a patient's socio-economic status which is more determinate of health status (along with individual behavior) than direct medical care. (It is sobering to note half of Medicare beneficiaries have annual incomes less than $22,500 and for Medicare minority's annual income is less than $15,000.)

NAACOS also supports measures or other incentives that attempt to reduce medical errors and health care disparities. Scholars at Johns Hopkins and elsewhere estimate medical errors are the third leading cause of death. A 2010 HHS report found during a one month period in 2008, 134,000 Medicare beneficiaries experienced at least one adverse event while hospitalized which contributed to the death of 15,000 Medicare patients. NAACOS supports efforts to reduce disparities in health care delivery and outcomes since among other things AHRQ's most recent annual disparities report shows that among 93 disparity measures only one measure showed improvement. Leaving aside the far greater benefit of reducing human suffering, what would be

the savings if amputation rates for diabetic African Americans were not five times higher than for whites? Sadly, the 2011 final ACO rule is silent on this issue.

We support wider reimbursement for telehealth services primarily because these services are generally a proven substitute for in-person primary care and chronic management services particularly highly prevalent chronic conditions such as CHF and COPD. (See our related comments below concerning the proposed chronic care management reimbursement.) We applaud CMS's recent release of an RFI seeking input to "increase patient engagement of Medicare beneficiaries." Health care ranks last among 14 industries in consumer engagement and half of all patients leave a medical visit not knowing what was recommended. We would encourage CMS to go further and actively work to improve provider-patient communication. We are not surprised in the slightest to learn the just released Commonwealth Fund issue brief, "Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program," concluded that while the 18 complex care management programs studied used a variety and combination of qualitative and quantitative methods they all focused on "building trusting relationships with patients."

Accelerating HIT

(Per mention of the proposed change to ACO #11 at page 419 of the proposed rule, please see our related comments above.) We agree with CMS's decision not to propose any new requirements regarding EHR based reporting and we agree with the proposal to align the MSSP with the EHR Incentive Program whereby an ACO can satisfy the CQM reporting component of meaningful use when an ACO extracts data to satisfy its GPRO reporting requirement using a CEHRT and reports the GPRO measures through the CMS web interface. Concerning CMS's interest in alternative methods of electronically reporting quality measures and or implementing EHB-based quality measure reporting either directly from EHRS or by other means and related questions, NAACOS is forming a work group to study and identify feasible alternatives to simplify collecting and reporting data via electronic means. We would be pleased to work with CMS on this subject going forward.

Quality Performance Benchmarks

Flat Percentages

CMS proposes to expand the use of flat percentages. On page 423 of the proposed rule CMS states it will use flat percentages to set the benchmark when "performance at the 60th percentile is equal to or greater than 80 percent for individual measures." On page 425 of the proposed rule CMS states further it will also use flat percentages "when the national FFS data results in the 90th percentile for a measure is greater than or equal to 95 percent" (and follows with "similar to our policy . . . of using flat percentages when the 60th percentile is greater than 80 percent to address clustered measures"). NAACOS supports the expanded use of flat percentages, however, we question whether the proposed change on page 423 obviates the need for the proposed change on page 425.

"Topped Out" Measures

For "topped out" measures or where "all but a very few of organizations achieve near perfect performance on the measure," CMS is considering dropping the measure/s from the measure set, folding them into a composite score (that presumably would be scored as all or nothing), retaining them as pay for reporting only or other option/s.

In a poll of our members, 79% either support making "topped out" measures pay for performance only (58%) or have them folded into a composite (21%). We believe the fact that a measure is topped out is unrelated to retiring it since this would imply the importance or value of whatever care provisioning the measurement assesses somehow becomes moot if and when the measure is

uniformly met. Additionally, since it's widely believed in health care that "what gets measured gets done" we are concerned retiring a measure may cause: a deterioration in the measured service; may contribute to the (legitimate) criticism health care delivery and outcomes lack transparency; and, would be counterproductive to patient education.

Second Participation Agreement
CMS proposes to require in the first year of a second, three year agreement that the ACO "would continue to be assessed on its performance on each measure that has been designated as pay for performance." That is the ACO would not be afforded another first-contract-year pay for reporting transition period.

NAACOS is hesitant to support the proposal if there are changes in the measure set. For example, if a 2013-2015 ACO chooses to sign a subsequent three year contract (for 2016-2018), one that forces it to accept risk, it could face new benchmarks beginning in PY '16 and it would not be afforded a one year transition pay for reporting period. See our related comments immediately below under "Timing for Updating Benchmarks."

Timing for Updating Benchmarks
CMS proposes to update the quality benchmarks every two years. CMS rationalizes this choice arguing "we do not have extensive experience in setting benchmarks under the Shared Savings Program" and this "would enable us to be more flexible." We believe the quality benchmarks should be updated no more frequently than every three years.

NAACOS strongly opposes updating the benchmarks every two years. First, in a poll of our members 64% believed benchmarks should be updated less frequently; 50% believed every three years; and, 14% believed every four years. Our members also believe when benchmarks are reset, ACOs should be afforded substantial advanced notice. In concert with a three year update, benchmarks should align with the three year contract period. This would provide ACOs confidence in knowing what they agreed to and would make moot CMS's concern that a three year update would advantage first year ACOs. Perhaps moreover, we find CMS's logic or priorities backward. ACOs should be afforded greater operating stability and an ability to gain competency in clinical practice reform (and in GPRO reporting). Instead, CMS is arguing improvements in provider practice and patient outcomes take a back seat to CMS "flexibility" to evolve its learning curve. Flexibility becomes moot if ACOs are never afforded adequate or sufficient time to gain competency in adapting to ever-changing benchmarks.

Rewarding Quality Improvement – Bonus Points
CMS proposes to better align the ACO and MA programs by adopting "a formula for quality improvement measures that MA has already developed and implemented." That is CMS is proposing to award up to two bonus points for quality improvement to each of the four ACO quality measure domains if the ACO achieves statistically significant improvement year-over-year. This would help ACOs achieve the maximum score of 14 or 16 points per domain.

We applaud CMS for recognizing the importance of quality improvement but believe the proposal needs to be strengthened. If an ACO were to score the maximum number of bonus points or eight (two per the four domains), this would provide at best a 14 percent improvement to its total point score. Our early estimates from member data indicates less than 5% of the ACOs will attain full points after the "report only" year. We believe therefore the proposal does not go far enough. The bonus points per domain should be increased to four. In a poll of our members, 90% support CMS award more than two bonus points and provide additional incentives for quality improvement. We also recommend bonus points be awarded even if they would exceed the total point scored per each domain. CMS states it did consider awarding up to four points but argues "we are not

proposing that option because we are concerned that awarding 4 points for the quality improvement measure could overweight the additional incentive for quality improvement." We find this logic flawed. Since the MSSP has just recently been launched the program should be largely about "improvement." (We would argue further, it should only be about improvement.) Therefore we believe it is impossible to "overweight" improvement – particularly since ACO shared savings is capped at 10 percent of total savings.

Additional Rewards for Quality Improvement

CMS also seeks alternative approaches to "explicitly rewarding quality improvement for ACOs." As Berenson and Kaye noted, still, seven years after being instituted, less than 30 percent of eligible professionals report PQRS data and those that do report tend to be larger, more resourced. This introduces a bias in the benchmarking database for ACOs, because: 1) the quality scoring system is still evolving; 2) benchmarking data is not representative of comparable FFS practices; 3) improvement should outweigh attainment; 4) care quality tends to vary substantially by region; and, 5) the proposed two bonus points provides limited reward for improvement. We offer two modest proposals to enhance quality improvement. First, we propose for those ACOs that score in the top 10 percent on quality measures they be awarded a quality financial bonus. We recommend the bonus be an additional 10 percent of share savings. Second, we propose ACOs be allowed to retain 50% of their share of savings regardless of the MSR, if their overall quality score improves year-over-year.

Chronic Care Management (CCM) Coverage

The 2015 proposed physician fee schedule rule includes a discussion to reimburse physicians for providing chronic care management beginning in January 2015. CMS states in a July 7, 2014 fact sheet the agency will pay $41.92 for the reimbursement code that can be billed no more frequently than once per month per qualified patient.

NAACOS applauds CMS's decision to reimburse for chronic care management. However, our members are moreover concerned the $42 reimbursement per patient per month is highly inadequate especially for the most complex patients and may be open to abuse by providers not sufficiently linked to the primary care physician. We believe adequate chronic care management far surpasses CMS's estimate of 20 minutes of clinical labor time per month particularly since, to qualify for the service, these patients suffer with at least two chronic care conditions. As the 2013 IOM report, "Shorter Lives, Poorer Health" notes, Americans suffer high rates of disabling disease with no discernable compression of morbidity, or disease with fewer consequences. Per CMS's own data, over a third (37%) of Medicare beneficiaries have four or more chronic conditions and nearly another one third (32%) have two to three conditions. (Among all Medicare beneficiaries, per CMS, 29% have arthritis, 28% diabetes, 16% heart failure, 15% kidney disease, 14% depression, 12% COPD, 11% Alzheimer's.) Even more significantly, as a 2011 Georgetown report by Komisar and Feder pointed out 15 percent of Medicare beneficiaries that have both chronic illness and long-term care needs (a population that disproportionately accounts for one-third of Medicare's total spending), however, Medicare does not pay for long term care services. Expecting ACOs or any other Medicare provider to successfully address this population (compounded by the fact Medicare does nothing formally to support family caregivers) with this disease prevalence for $42 per month is unreasonable. Also, we believe patient written approval creates an unnecessary barrier as does the patient copay and the requirement to use 2014 edition CEHRT. The 24/7 requirement while well intended will likely compromise smaller ACO provider participation and for obvious reasons any additional CCM income needs to be initially excluded in calculating an ACO financial benchmark. We are concerned providers not directly responsible for the care of the patient may bill for this service and therefore urge CMS to define the provision of these services be at the specific direction of the patient's principle physician or in their employ and monthly reports become part of that ordering physician's medical records.

We appreciate the opportunity to share our views on the ACO quality measures and performance benchmarks and Chronic Care Management fee under the 2015 PHYSICAN FEE SCHEDULE PROPOSED RULE [CMS-1612-P]. If you have any questions regarding this letter, please contact David Introcaso, NAACOS, Vice President for Policy at dintrocaso@naacos.com, (202) 737-4182.

Sincerely,

Clifton Gaus
CEO
National Association of ACOs