September 8, 2015

Mr. Andy Slavitt, MBA
Acting Administrator
Center for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Submitted via www.Regulations.gov

Re: Comment Letter Concerning the Proposed CY 2016 Physician Fee Schedule Rule (CMS-1631-P)

Dear Acting Administrator Slavitt:

The National Association of ACOs (NAACOS) is the largest organization of Medicare Shared Savings Program (MSSP) ACOs representing approximately 150 MSSP and Pioneer ACOs. NAACOS is a 501(c)(6) non-profit organization that works on behalf of our members to increase the quality of care quality, improve population health, and reduce cost growth. NAACOS respectfully submits the following comments and recommendations in response to the proposed Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, published in the Federal Register on July 15, 2015.

The Merit-Based Incentive Payment System (MIPS)

First, we appreciate mention of the Medicare Access and CHIP Reauthorization Act (MACRA) and the MIPS in the proposed rule. Additionally, we look forward to the forthcoming Request for Information (RFI) document related to "the criteria and process for the submission of physician-focused payment models eligible APMS, qualifying APM participants." Here we will limit our comments to "clinical practice improvement activities."

We believe all six "clinical practice improvement" subcategories are relevant and important.

1. Practice Access: ACO measure #1, getting timely care, appointments and information and #4, access to specialists, reflect this importance. We believe these measures or related measures ought to remain as a part of the "clinical practice improvement" component measure.
2. Population Management: Since there is no agreed upon definition of the term population health, CMS should offer a definition for public comment. This point aside, we believe some measurement of the provider's population in sum ought to be considered, e.g., reduced disparities or lowered mortality. The population's health outcomes and/or the distribution of health care services should be better understood in addition to the continued "monitoring health conditions of individuals." We'd be remiss if we did not comment on risk adjustment in this context: CMS risk adjustment is not consistent across Medicare programs and populations. Since MACRA is in part an attempt to consolidate several disparate existing Medicare incentive programs, the agency should not ignore risk adjustment.

3. Care Coordination: It is simply impossible in today's world to credibly "coordinate care" without (fully) utilizing telehealth and remote patient monitoring technologies. The commercial market and the VA are ever-increasingly using these technologies.
4. Beneficiary Engagement: obviously, this starts with engaging the patient. CMS must allow ACOs to do so via beneficiary attestation. Additionally, CMS should begin to allow providers to demonstrate the use of "shared decision making mechanisms" where and/or when appropriate.
5. Patient Safety: health care sadly remains unsafe and at times dangerous. CMS should, at least, recognize providers that avoid low and no value services.
6. Alternative Payment Models: this should include any and all ACOs since ACO providers, without exception, have put at risk significant financial investments in startup, staffing, practice redesign and quality measurement reporting and continue to risk additional operating costs each year.

Establishing Separate Payment for Collaborative Care

In the preamble, CMS recognizes that care management for Medicare beneficiaries with multiple chronic conditions, particularly complicated diseases or acute conditions, often requires extensive discussion, information-sharing and planning between a primary care physician and a specialist[1]. In CY 2014, four CPT codes (99446-99449) were created that describe inter-professional telephone/internet consultative services. CMS currently does not make separate payment for these services. In the preamble, CMS notes that it is considering how to improve the accuracy of payments for care coordination, particularly for patients requiring more extensive care, and requests comments on how Medicare might accurately account for the resource costs of a more robust interpersonal consultation.

A core component of quality palliative care is communication – communication with patient, family, and other loved ones, communication with all involved primary care, and specialty providers; communication with community services such as food services, transportation, home care agencies, hospice, and long term care facilities. Such communication is the dominant activity in palliative care, much of it telephonic and electronic, occurring between and during face to face to face visits.

NAACOS considers it appropriate to provide payment for these services, as this will encourage providers to more diligently communicate with other treating providers. It is important for a physician to speak to another treating provider when a patient with multiple or serious diagnoses has a change in health status, or is transitioning to a new setting. NAACOS recommends that when a provider bills at a 4 or 5 level of complexity and/ or when a clinician has billed one of the time extender codes (99356 or 99357), this should indicate that it would be appropriate to bill for collaborative care services as well. The documentation requirements should include the nature of the change in status or transition and language to support that a conversation between providers has happened. Valuation of these codes should be similar to the time extender codes that CMS has already valued. Finally, CMS should, as professional membership organizations and others have argued, publish the RUC-recommended values for all codes.

CCM and TCM Services

In 2013 CMS implemented a separate payment for transitional care management (TCM) services and in 2015 implemented a separate payment for chronic care management (CCM) services. In the preamble, CMS notes there are more extensive requirements for TCM and CCM services compared to other evaluation and management services, and questions whether these requirements are impeding the ability to provide these services to beneficiaries.

NAACOS appreciates CMS's recognition that services provided under the TCM and CCM codes require more extensive requirements than other evaluation and management services. We are concerned that these additional requirements hinder a provider's willingness to engage in TCM and CCM services, which help to ensure that a beneficiary's care is coordinated across multiple providers and settings of care. CMS should consider increasing the amount of the reimbursement to be more in line with the

[1] 80 Fed. Reg. at 41710.

services that are being provided. Increased value in the reimbursement could encourage more providers to utilize these codes. Research has demonstrated that good care management can help avoid costly trips to the emergency room, hospital admissions or readmissions. Thus, the widespread use of these codes has the potential to improve quality of care while reducing health care expenditures.

At the same time, the current CCM codes target a patient who can be managed according to disease-specific clinical guidelines. These codes are not appropriate when coordinating care for more complex patients. These sickest Medicare beneficiaries are patients who cannot or should not be treated using standardized guidelines. We encourage CMS to establish a separate code for complex chronic care management that recognizes the differences in the scope of services required for this patient population, as well as the type and intensity of physician supervision and the type and intensity of clinical staff resources required to perform complex chronic care management.

Advance Care Planning Services

In CY 2015, the CPT Editorial Panel created two new codes describing advance care planning (ACP) services:

- CPT code 99497: Advance care planning including the explanation and discussion of advance care directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate.
- Add-on CPT code 99498: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; each additional 30 minutes (List separately in addition to code for primary procedure)).

In the CY 2015 Medicare Physician Fee Schedule final rule, CMS assigned these codes a status indicator of "I" (not valid for Medicare purposes). CMS now seeks comment on whether payment for advance care planning is needed and what types of incentives this proposal creates. CMS notes that the ACP services should be reported when "the described service is reasonable and necessary for the diagnosis or treatment of illness or injury." (Section 1862(a)(1)(A) of the Act) CMS also seeks comment on whether payment for ACP is appropriate in other circumstances, such as an optional element at the beneficiary's discretion at the time of the annual wellness visit.

NAACOS strongly supports payments for these two codes. Many ACOs devote significant time and resources to training their clinical staff on how to discuss sensitive end-of-life issues with their patients and how to appropriately document patient preferences. Some medical groups have implemented formal physician/patient engagement programs to provide specialized training in effective advance care planning. We are therefore encouraged by the proposals to reimburse for these services, which will support these critical activities at the right time for patients. CMS is proposing to adopt RUC-recommended values for these codes, but CMS states that absent a Medicare national coverage determination, Medicare Administrative Contractors (MACs) are responsible for making local coverage decisions to implement the codes. We would request that clear direction be given to the MACs so that these important services will be reimbursed in a consistent manner throughout the country.

Proposed MSSP Statin Measure

CMS proposes to add a 34th measure to the MSSP measure set through the CMS web interface to the preventive health quality measure domain. We support the addition of a measure of statin therapy for the prevention and treatment of cardiovascular disease to be a single measure, not three measures or as the proposed rule states the multiple denominators be equally weighted when calculating the performance rate. We also support the proposal to increase the size of the over-sample from 616 to 750 or more beneficiaries. Finally, as CMS notes, due to multiple denominators for a single measure, we support the measure be pay for reporting for the entire agreement period and that it be scored as two points.

Concerning CMS's request for "public feedback on the benchmarking approach for the [statin] measure", we believe the measure should be pay for reporting for at least three years since this a new measure with the novel application of multiple denominators. CMS should collect and evaluate ACO performance over a period of time before determining how the measure should be benchmarked. If CMS chooses to take the benchmarking approach per the November 2, 2011 MSSP final rule, the agency will set the statin measure benchmark using national Medicare FFS claims data and MA quality data. We note that the size of group practices reporting via the web interface varies widely (beginning with 25 providers) and group practices are encouraged to report on measures that are for "conditions usually treated" and "types of care typically provided." When quality scoring is determined by the national 30th percentile level of performance (or not at a national flat 30 percent) ACOs can be and often are disadvantaged because their scores do not account for their comparative size or the fact they do not choose their quality measures. Absent refining ACO quality scoring to account for these dissimilarities, CMS should reconsider, as it noted in its 2011 MSSP final rule, comparing "an ACO's quality performance to the performance of other ACOS." (FR pg. 67898)

Outdated MSSP Measures

We agree with the logic proposed concerning outdated measures, namely that CMS will "reserve the right to maintain a measure as pay for reporting, or revert a pay-for-performance measure to pay for reporting, if a measure owner determines the measure no longer meets best clinical practices due to clinical guidelines updates or clinical evidence suggests the continued application of the measure may result in harm to patients."

MSSP Measure #11

CMS seeks comments on how the agency might evolve MSSP measure #11 or the "percent of PCPs who successfully met meaningful use requirements." We believe this measure should be evolved at least in part since MACRA legislation will include a "meaningful use" component of the MIPS composite score.

Rewarding Higher Levels of IT Adoption

CMS asks on page 537 in the proposed rule about ways to "reward providers who have achieved higher levels of health IT adoption." In previous NAACOS comments to CMS, we argued that the agency should reward ACOs a higher percent of earned shared savings or higher than 50 percent for Track 1 ACOs for superior quality performance. Specifically, in our February 6, 2015 comment letter in response to the December 2014 proposed MSSP rule that was co-signed by the entire MSSP stakeholder community, we urged CMS to reward up to 10 percentage points of additional shared savings, or 60 percent under Track 1, for top quartile quality performance. For example, ACOs that score the maximum of four points for measure #11 and have exceeded their MSR should receive an additional percent of net shared savings, or savings after their overall quality score is factored.

Proposed Changes to MSSP Assignment via SNF and ETA Codes

We agree with the proposal to amend the definition of primary care services for the purposes of MSSP assignment to exclude CPT codes 99304-18 when the claim includes the POS 31 modifier. We also agree with the proposal to include HCPCS code G0463 when submitted by an ETA hospital as a primary care service again for the purpose of determining MSSP beneficiary assignment.

Thank you for your consideration of our comments,

Clifton Gaus
CEO