December 28, 2017

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

Re: (CMS-5522-FC) Medicare Programs: CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year

Dear Administrator Verma:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments on the final rule outlining policies for the Calendar Year 2018 Quality Payment Program (QPP). The QPP has a profound impact on ACOs which have a place in both the Advanced APM and Merit-Based Incentive Payment System (MIPS) pathways of the program.

NAACOS is the largest association of ACOs, representing more than 4 million beneficiary lives through more than 270 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 part of the agency's implementation of the Medicare Access and CHIP Reauthorization Act (MACRA), we urge CMS to:

- **Maintain the 8 percent revenue-based nominal risk threshold in future years, remove Part A expenditures and lower the benchmark-based risk standard;**
- **Provide Qualifying APM Participant (QP) notifications at the ACO level and provide detailed information about an ACO's QP score;**
- **Simplify the risk criteria and overall process related to the All-Payer Combination Option and allow qualifying Other Payer APM designations to last more than one year;**

- **Move forward with plans to establish a demonstration to provide credit for Medicare Advantage Advanced APM participation in 2018 and allow ACOs to participate;**
- **Provide ACOs with direct communication including clear and concise language regarding how ACO practices must report Advancing Care Information (ACI) for those providers meeting ACI zero-weighting requirements, as well as how these providers will impact the ACO practice and overall ACO score in the ACI performance category;**
- **Adopt an alternative methodology for making quality comparisons in MIPS to create more equitable benchmarks across reporting mechanisms; and**
- **Exclude MIPS payment adjustments as ACO expenditures.**

Advanced APM Recommendations

Advanced APM List

Key Comment:

- **NAACOS strongly supports including a number of ACO models on the 2018 Advanced APM list, but we urge CMS to reconsider its previous decision on Track 1 and to include MSSP Track 1 as an Advanced APM.**

Comment: We are extremely pleased that a number of ACO models including MSSP Track 1+, 2 and 3 and the Next Generation ACO Model are on the list of 2018 Advanced APMs. These ACOs are at the forefront of improving the health of populations, reducing per capita costs of health care, and enhancing the experience of care. We are proud to include many of these ACOs as our members and look forward to working with CMS to refine and advance these ACO models to ensure their long-term success. However, we urge CMS to reverse its decision and include MSSP Track 1 as an Advanced APM. Track 1 ACOs have been leaders in the transition to value-based payment models and have significantly invested in their development and early success. Excluding these ACOs undermines this important transition, and we strongly recommend CMS include Track 1 MSSP as an Advanced APM.

Advanced APM Risk Requirements

Key comments:

- **NAACOS supports CMS final policy to maintain the 8 percent Advanced APM revenue-based nominal risk threshold for 2019 and future years.**
- **NAACOS requests that CMS lower the Advanced APM benchmark-based risk threshold and remove Part A revenue from the revenue-based threshold.**
- **NAACOS urges CMS to reconsider the decision to not account for ACOs' significant investment costs, and we urge CMS to develop a process to account for ACO costs and investments to allow those to qualify for the nominal amount standard.**

Comment: We strongly support CMS's decision to maintain the 8 percent threshold for the nominal amount standard and urge the agency to not increase this in future years. While we strongly support a revenue-based risk threshold, we request that CMS 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 Entities 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 on how this affects 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.

We urge CMS to lower the 3 percent benchmark-based standard to a more appropriate threshold of 1 percent. While the agency lowered the benchmark-based threshold from the proposed 4 percent to 3 percent in the final 2017 QPP rule, this threshold is still too high for many provider organizations including ACOs. We argue that 4 percent of total Medicare Parts A and B expenditures is far more than "nominal risk." In fact, the Regulatory Impact Analysis of the final 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.

We also urge CMS to account for the significant investments ACOs make in start-up and ongoing costs and to include these as part of the definition and calculation of risk. We are very disappointed that CMS policy disregards these investments by not including them in 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 create a method to account for these investments. ACO investments include start-up and operating costs to help fund critical ACO activities designed to improve beneficiary care, enhance care coordination, and reduce unnecessary spending and hospitalizations. We urge the agency to recognize these investment costs and consider them as risk, thus allowing Track 1 ACOs an opportunity to qualify as Advanced APMs. Specifically, we urge CMS to develop a mechanism to account for the substantial investments ACOs make, including those related to clinical and care management, health IT/population analytics/reporting, and ACO management and administration.

Qualifying APM Participant (QP) Determinations

Key Comment:

- **NAACOS urges CMS to provide QP notifications at the ACO level and to provide detailed information about an ACO's QP score.**
- **NAACOS urges CMS to modify Next Generation ACO policies to allow ACOs to submit supplemental participant list changes during the measurement year to allow the maximum number of its participants to be considered for the QP evaluation.**

Comments: During PY 2017, CMS began providing QP notifications for each snapshot date through a look-up tool for providers, which will continue to be updated to reflect future QP determinations. The tool requires entering an individual provider's National Provider Identifier (NPI) and does not allow APM Entities such as ACOs to look up the APM Entity's QP status. Since ACOs are evaluated based on the collective group of ECs in the ACO, it is important to provide QP status information at the APM Entity level. We urge CMS to modify the tool as soon as possible to allow APM Entities to look up their QP status as an APM Entity. Further, ACOs need to understand details about their QP score, which is important information to plan for the future as QP thresholds rise. We request that the agency provide the ACO's specific QP score for each snapshot date as part of the overall QP determination.

Under existing program rules, there is a six-month lag between when a Next Generation ACO must submit its participant list to CMS for a given performance year and the start of that performance year (i.e., an Next Generation ACO must submit its participant list for 2018 in mid-June 2017). Only providers on that list are included for Advanced APM bonuses for the following performance year. If a physician joins the Next Generation ACO July 1, 2017, he or she would be ineligible to receive an Advanced APM bonus until 2021. A three-and-a-half-year delay for a provider actively engaged in an Advanced APM is unreasonable and undermines participation in Advanced APMs. We urge CMS to modify Next Generation ACO policies to allow ACOs to submit supplemental participant list changes during the measurement year to allow these participants to be considered for the QP evaluation**.**

All-Payer Combination Option

Performance Period and Risk Criteria

Key comments:

- **NAACOS supports CMS's addition of the Other Payer revenue-based nominal amount standard and urges the agency to focus this threshold only on physician revenue.**
- **NAACOS urges CMS to not require higher or more complicated risk levels, compared to Medicare APM thresholds, for Other Payer APMs to qualify as Advanced APMs.**
- **NAACOS supports CMS's plan to establish a demonstration to provide credit for Medicare Advantage Advanced APM participation in 2018 and urges ACOs be eligible to participate.**

Comments: We strongly support CMS's final policy establishing a revenue-based standard for Other Payer APMs and aligning that standard with what is used for Advanced APMs under the Medicare Option. There is an ongoing evolution of APM arrangements in commercial markets with risk based on revenue or total expenditures, and it is important to allow either type of risk arrangement to qualify as meeting nominal amount standards. However, we urge CMS to focus the revenue-based threshold only on physician revenue, which matches our recommendation for the Medicare revenue-based threshold.

In the final 2018 QPP rule, CMS requests feedback on its previously finalized requirements related to Other Payer APM minimum loss rates (MLR) and shared loss rates. We request the agency remove requirements that, except for Medicaid Medical Home Models, a qualifying Other Payer risk arrangement must have a shared loss rate of at least 30 percent and a MLR at or below 4 percent. CMS did not finalize its proposed shared loss rates or MLRs for Advanced APMs under the Medicare Option 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. 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. Setting realistic and appropriate thresholds for Other Payer APMs will be especially important in later years when QP thresholds are higher. We urge CMS to survey payers outside Medicare on their risk arrangements and share that information with stakeholders. There is no reason that the risk thresholds for Other Payer APMs should be higher or more complicated than what is required for Medicare Advanced APMs, and we request CMS remove these requirements.

As detailed in a previous letter to CMS, we urge the agency to alter its regulations to allow clinicians' contracts with Medicare Advantage (MA) plans that meet the Other Payer requirements to be included in the QP determination as soon as possible. We support CMS's plan to develop a demonstration in

2018 to test the effects of incentives for participating in APMs under MA that qualify as Advanced APMs, and we underscore the need to allow ACOs to participate along with other providers.

Other Payer CEHRT Requirement

Key Comment:

- **NAACOS urges CMS to provide more flexibility for meeting Other Payer CEHRT requirements.**

Comments: We appreciate CMS's effort to simplify qualifying for Other Payer CEHRT by presuming that an Other Payer arrangement meets the 50 percent CEHRT use criterion if CMS receives information and documentation through the Eligible Clinician Initiated Process showing that the Other Payer arrangement requires the requesting EC to use CEHRT to document and communicate clinician information. However, we urge the agency to go farther and provide even more flexibility by removing the 50 percent requirement altogether. While CEHRT use is required by MACRA, CMS should not be overly prescriptive about this requirement considering the variability in commercial contracts, many of which do not address CEHRT requirements in the same manner as Medicare. The agency should alleviate administrative and regulatory burdens in this area to the greatest extent permitted under law, and we therefore recommend CMS strike the 50 percent requirement.

Process for Qualifying for All-Payer Advanced APM Participation

Key Comments:

- **NAACOS supports CMS's decision to allow QP determinations at the APM Entity level.**
- **NAACOS urges CMS to significantly modify the process for qualifying under the All-Payer Combination Option by simplifying and streamlining the process and allowing determinations of Other Payer APMs to last beyond one year.**

Comments: We strongly support CMS's decision to allow evaluation of Other Payer participation at the APM Entity level, not just at the EC level as proposed. We appreciate the final policy, which reinforces the collective focus of the APM Entity and streamlines the process for submitting information for All-Payer QP evaluations. CMS notes in the final rule that in cases where QP determinations are requested at the APM Entity level, the agency expects that the composition of the APM Entity will be "generally consistent" across the Medicare Advanced APM(s) and Other Payer Advanced APM(s). Should that not be the case, CMS expects the EC would request the QP determination at the EC level. Feedback from our members indicates that there is often variability between the Medicare ACO composition and the composition of providers in Other Payer APMs. As such, we urge CMS to allow considerable flexibility for the determination of what is considered to be "generally consistent". This flexibility will allow ACOs to submit information at the APM Entity level and avoid the incredibly burdensome process of having to collect and submit information at the EC level.

The overall process to qualify under the All-Payer Option is prohibitively complicated and needs to be dramatically simplified. Without significant modification, the weight of the regulatory burden will likely cripple meaningful participation. We urge CMS to modify this process and implement a more streamlined and efficient path for providers to qualify for Advanced APM bonuses through the All-Payer Option. As part of a revised approach we urge CMS to require MA and state Medicaid agencies to submit information to CMS on their APM arrangements. If CMS is truly committed to advancing value-based payment, submission of this information by payers that work closely with the agency should be mandatory. We also request that the agency not require Other Payer APM determinations annually, which is unnecessary and creates added work for all involved. Many commercial APM arrangements last for more than one year, and it is not uncommon for an arrangement to be in place

for two to four years. Similar to the three-year agreement periods with MSSP, providers make significant investments in and commitments to participating in Other Payer APMs, which is why they often are multi-year agreements. As an alternative to annual determinations, CMS should require a simple attestation annually to confirm no material changes have occurred that would change the Other Payer Advanced APM determination.

A number of forms to be used in the process for evaluating Other Payer APM arrangements will be developed at a later time. It is essential that CMS collect stakeholder feedback on these forms, which will have a significant effect on the success of the All-Payer Combination Option. We urge CMS to simplify the approach to evaluating Other Payer arrangements by using attestation rather than requiring submission of detailed information and supporting documentation.

Calculation and Payment of APM Bonus

Key Comments:

- **NAACOS urges CMS to pay the Advanced APM bonus directly to the APM Entity rather than directly paying the participant TINs within an ACO.**
- **NAACOS recommends including ACO shared savings payments as supplemental service payments in the calculation of the APM incentive payment amount.**

Comments: We strongly recommend CMS change the policy regarding payment of the Advanced APM bonus by paying the bonus to the APM Entity - just as CMS pays an ACO for shared savings rather than directly paying the participant TINs or providers comprising an ACO. This approach would allow ACOs to allocate incentive payments fairly and accurately in accordance with the shared risk for individual clinicians in the APM Entity. CMS should also modify its policy for identifying supplemental payments to be included in the Advanced APM bonus calculation. The current policy excludes ACO shared savings payments from the calculation, which ignores the goals of population-based payment models that strive to *decrease* traditional spending through care coordination and alternative approaches to providing care. ACO providers work to lower their spending, which under CMS's Advanced APM bonus calculation, penalizes them by also lowering their bonus. We urge CMS to include ACO shared savings payments as supplemental service payments in the calculation of the APM incentive payment amount.

MIPS Recommendations

MIPS Performance Threshold and Incorporating Cost in MIPS Scores

Key Comments:

- **NAACOS thanks CMS for adopting our recommendation to begin holding clinicians accountable for both cost and quality by incorporating a 10 percent cost score for the 2018 performance year of MIPS.**
- **We urge CMS to hold clinicians accountable in the MIPS program and reward high-performing clinicians who have invested heavily in performance improvement and should therefore be rewarded for this investment, time, and effort.**

Comment: NAACOS supports CMS's decision to finalize a policy to incorporate a 10 percent cost category in MIPS for 2018. However, NAACOS is concerned that CMS's policies that exempt so many additional clinicians and dilute performance requirements in year two of the MIPS program will discourage 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 been pioneers in the commitment to value-based health care and may lose momentum in encouraging those currently progressing along this continuum. **We urge CMS to continue to encourage providers to accept accountability for cost and quality by fully implementing the MIPS program as intended.**

Counting MIPS Payment Adjustments as ACO Expenditures

Key Comment:

- **NAACOS urges CMS to exclude MIPS payment adjustments as ACO expenditures.**

Comment: 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 continuing their focus 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. 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, and 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. 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.

MIPS APM Scoring Standard, 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.**

Comment: CMS did not make changes in the way points are assigned in the quality performance category. As was the case in PY 2017, in PY 2018 CMS will score quality measure performance under the APM scoring standard using a percentile distribution, separated by decile categories. For each benchmark, CMS will calculate the decile breaks for measure performance and assign points based on the benchmark decile range into which the APM Entity's measure performance falls. CMS plans to continue to use a graduated points-assignment approach, where a measure is assigned a continuum of points out to one decimal place, based on its place in the decile.

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 electronic health record (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

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.

MIPS APM Scoring Standard, Providing Favorable Reporting Requirements and Scoring for ACOs

Key Comment:

- **NAACOS supports CMS's decision to continue to provide favorable scoring and reduced reporting burdens under MIPS for ACOs.**

Comment: NAACOS supports CMS's continued efforts to reduce reporting burdens for ACOs subject to MIPS. We support the APM Scoring Standard and the policy providing ACOs with full credit under the Clinical Practice Improvement Activities performance category. It is critical that CMS continue to adopt policies which reduce reporting burdens for ACOs subject to MIPS. ACOs are already focused on providing high quality care and have a deep commitment to performance improvement. We appreciate CMS's continued support for ACOs by providing favorable benefits to ACOs in MIPS.

MIPS APM Scoring Standard, Advancing Care Information Exclusions

Key Comment:

- **NAACOS urges CMS to provide ACOs with direct communication including clear and concise language regarding how ACO practices must report ACI for those providers meeting ACI zero-weighting requirements, as well as how these providers will impact the ACO practice and overall ACO score in the ACI performance category.**

Comment: CMS attempted to make several clarifications regarding how ACO practices should report ACI for those providers who would otherwise meet zero weighting for the ACI performance category. However, this language remains unclear and subject to interpretation. In fact, throughout 2017 CMS staff have given ACOs conflicting information regarding how this issue will be handled. Therefore, we urge CMS to directly communicate to ACOs how they must report ACI for those providers meeting ACI zero-weighting requirements, as well as how these providers will impact the ACO practice and overall ACO score in the ACI performance category. **We urge CMS to provide this guidance as soon as possible in the form of a clear and concise FAQ and notice in the ACO Spotlight Newsletter so that the agency can communicate this critical information to ACOs as soon as possible.**

In the final 2017 QPP rule CMS states that the agency will aggregate ACI Tax Identification Number (TIN) performance for those using the group reporting option, regardless of ECs meeting certain exemptions for a re-weighting of this performance category such as non-patient facing, non-physician practitioner, or hospital-based or Ambulatory Surgical Center (ASC) exceptions. Specifically, on page 30079 CMS states,

> The data submission criteria for groups reporting advancing care information performance category described in the Calendar Year 2017 QPP final rule state that group data should be aggregated for all MIPS eligible clinicians within the group practice. This includes those MIPS eligible clinicians who may qualify for a zero percent weighting of the advancing care information performance category due to circumstances as described above such as a significant hardship or other type of exception, hospital-based or ASC-based status, or certain types of non-physician practitioners (Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists and Clinical Registered Nurse Anesthetists).

However, in the final 2018 QPP rule, CMS includes two clarifying paragraphs relevant to this issue, which need further clarification. Specifically, on page 53701, CMS states:

> We note that group level advancing care information reporting is not negatively affected by the failure of a single individual to report because it is based only on average reported performance within the group, not the average reported performance of all eligible clinicians in the group—those who do not report are not factored into the denominator. If, however, all MIPS eligible clinicians in a TIN qualify for a zero percent weighting of the advancing care information performance category, the entire TIN will be removed from the numerator and denominator, and therefore contribute a null value when calculating the APM Entity score.

On page 53701 CMS also states:

> In the CY 2018 Quality Payment Program proposed rule, we proposed that under the APM scoring standard, if a MIPS eligible clinician who qualifies for a zero percent weighting of the advancing care information performance category in the final score is part of a TIN reporting at the group level that includes one or more MIPS eligible clinicians who do not qualify for a zero percent weighting, we would not apply the zero percent weighting to the qualifying MIPS eligible clinician, and the TIN would still report on behalf of the entire group, although the TIN would not need to report data for the qualifying MIPS eligible clinician. All MIPS eligible clinicians in the TIN who are participants in the MIPS APM would count towards the TIN's weight when calculating an aggregated APM Entity score for the advancing care information performance category.

Though this language is not clear, we interpret these passages to mean ACO practices do not need to report on clinicians like hospital-based clinicals who would be eligible for a zero-weighting of ACI. These clinicians would not be included in the denominator, but all clinicians billing under the TIN would be factored into calculations for determining the number of clinicians in each practice to devise the weighted average ACI score for the ACO entity. We urge CMS to confirm this understanding by issuing ACOs with clear guidance on this issue.

It is critical that CMS exclude clinicians meeting ACI zero-weighting requirements ("special status") from the TIN ACI information reported to CMS. ACOs must use the group ACI reporting option for each ACO participant TIN. These scores are then averaged to come up with one ACO-entity level ACI performance category score. Because ACOs are required to have TINs report ACI data to CMS, they should not be unfairly penalized by having to include these scores which could otherwise be excluded if the provider was not included in an ACO. Many of these clinicians were not previously required to participate in the legacy program, Meaningful Use, and will find very few measures applicable to report in ACI.

Finally, we urge CMS to also provide more timely information to ACOs regarding operational details necessary to report using the TIN reporting function for ACI. CMS has noted there will be additional guidance in this area, however at the time of submitting these comments ACOs lack key details they require to successfully collect and report this data to CMS. We urge the agency to provide detailed guidance regarding TIN reporting of ACI, for example, providing more detailed explanations of how to count unique patients when aggregating performance data across the TIN and detailed guidance regarding how to report such data to CMS.

Conclusion

Implementing meaningful opportunities for providers under MACRA will help modernize Medicare and affect providers for years, if not decades to come. ACOs play an integral role in moving the health system into a new era of high quality patient-centered care with reduced unnecessary costs and utilization. We urge CMS to consider the feedback included in this letter and thank you for your consideration of our comments. Should you want to further discuss any of our recommendations, please contact me at abrennan@naacos.com.

Sincerely,

Allison Brennan
Vice President of Policy
National Association of ACOs