December 19, 2016

Mr. Andrew Slavitt
Acting 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-5517-FC) Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models

Dear Acting Administrator Slavitt:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) final rule with comment period, *Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models,* published in the *Federal Register* on November 4, 2016.

NAACOS is the largest association of ACOs, representing over 3.13 million beneficiary lives through 210 Medicare Shared Savings Program (MSSP) ACOs, Next Generation, Pioneer 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 healthcare 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 for Medicare beneficiaries, reduce healthcare costs, and improve quality in the Medicare program.

ACOs represent a refined approach to the delivery of health care and were created through a bipartisan effort to facilitate coordination and cooperation among providers to improve the quality of care and to reduce unnecessary costs. ACOs are the type of model that Congress intended to support through MACRA, and we urge CMS enact the recommendations in this letter to further support the ACO model so that it may achieve long-term success as a premier Medicare APM.

Summary of Key Recommendations

As part of the agency's MACRA implementation, we urge CMS to:

- **Reconsider the decision to exclude Track 1 as an Advanced APM and add Track 1 to the list of Advanced APMs.**
- **Develop Track 1+ quickly as an Advanced APM in 2018 and make it broadly available to ACOs**
- **Remove Part A revenue from the Advanced APM revenue-based nominal risk threshold and maintain the 8 percent threshold at least through 2020**
- **Change the policy prohibiting ACO primary care practices selected for CPC+ to be eligible for the Advanced APM bonus.**
- **Develop a process to account for ACO costs and investments to allow those to qualify as meeting standards for more than nominal risk.**
- **Pay the Advanced APM bonus directly to the APM Entity just as CMS pays the ACO for shared savings rather than directly paying the participant TINs within the ACO.**
- **Align standards for Other Payer APMs with Medicare APM standards and do not require higher or more complicated risk levels for Other Payer APMs to qualify as Advanced APMs.**
- **Clarify the total available points for ACOs in the quality performance category.**
- **Make changes to MIPS quality benchmarking methodologies to make more accurate comparisons.**
- **Clarify that ECs in ACOs will be provided the same exemptions from ACI scoring as those not in ACOs.**
- **Provide additional guidance regarding how ACI group reporting will be accomplished for ACOs reporting ACI.**
- **Publish updated measures specifications for the revised ACO-11 measure promptly so ACOs can make the necessary operational changes to be able to report this measure.**
- **Finalize a policy whereby MIPS APM payment adjustments will not be counted as benchmark expenditures for purposes of evaluation under ACO programs.**

Advanced APM Recommendations

Advanced APM List

Key Comments:

- **NAACOS strongly supports that MSSP Tracks 2 and 3 and the Next Generation ACO Model are on the final Advanced APM list, but we urge CMS to reconsider its decision on Track 1 and to include MSSP Track 1 as an Advanced APM.**
- **NAACOS urges CMS to change the policy prohibiting ACO primary care practices selected for CPC+ to be eligible for the Advanced APM bonus.**

We are extremely pleased that Track 2 and 3 of the MSSP and the Next Generation ACO Model are on the final list of Advanced APMs. These ACOs represent the forefront of organizations dedicated to enhancing the experience of care, improving the health of populations, and reducing per capita costs of health 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 moving forward to ensure their long-term success. However, based on the reasons outlined in this letter, we urge CMS to reverse its decision and include MSSP Track 1 as an Advanced APM. Track 1 ACOs have been at the forefront of 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.

The Comprehensive Primary Care Plus (CPC+) model is included as an Advanced APM, which is the only Advanced APM to qualify under the Medical Home Model criteria. We were very pleased that this summer CMS reversed its initial decision to exclude MSSP ACO primary care practices from participating in CPC+. However, in the agency's updated CPC+ FAQs, CMS notes that MSSP Track 1 practices selected for CPC+ would not be eligible for the Advanced APM bonus based on their MSSP participation. This makes little sense as these providers would be participating in two of CMS's premier APMs, one of which is included on the Advanced APM list. The unintended consequence of withholding the APM bonus from these practices would be to incentivize them to leave their ACO to participate in CPC+ on their own and earn the APM bonus. By putting primary care practices in this either/or position, CMS will slow the adoption of accountability for total cost of care, the greatest opportunity to bend the cost curve. We urge CMS to change its policy and allow ACO primary care practices selected for CPC+ to be eligible for the Advanced APM bonus.

Financial Risk Criteria for Advanced APMs (other than Medical Home Models)

Key Comments:

- **NAACOS recommends CMS work with ACO stakeholders to develop a new option for ACOs to repay losses through a reduction of future payment rates to the ACO's participant TINs/eligible clinicians.**
- **NAACOS urges CMS to reconsider the decision to not account for ACOs' significant investment costs, and we strongly recommend CMS consider these investments as risk, thus allowing Track 1 ACOs to qualify as Advanced APMs.**
- **NAACOS urges CMS to develop a process to account for ACO costs and investments to allow those to qualify as meeting standards for more than nominal risk.**

We support CMS's final policy that allows Advanced APMs to meet a generally applicable financial risk standard such that if an Advanced APM's actual expenditures for which the APM Entity is responsible exceed expected expenditures during a specified performance period, CMS would:

- Withhold payment for services to the APM Entity and/or the APM Entity's eligible clinicians;
- Reduce payment rates to the APM Entity and/or the APM Entity's eligible clinicians; or
- Require the APM Entity to owe payment(s) to CMS.

Under these financial risk standards, the agency will allow a reduction of payment rates to the APM Entity and/or the APM Entity's eligible clinicians as one option for repaying losses. We urge CMS to develop an option for ACOs to repay losses through reduced payment rates of the ACO's eligible clinicians in future years. Through this mechanism, CMS would identify the Tax Identification Number (TIN)/National Provider Identifier (NPI) combinations that participate in the ACO for a specific performance period and, similar to downward payment adjustments under MIPS, CMS would reduce the payment rates for those TIN/NPIs by a certain percent in a future payment adjustment year to recoup the ACO's losses. ACOs would include language in the agreement between the ACO and its participant TINs and their individual practitioners detailing specifics of this repayment mechanism. Allowing ACOs to choose this as one of the mechanisms to repay losses would provide a new option that some ACOs may prefer over repaying losses in a lump sum. We urge CMS to work collaboratively with us to further develop this concept and the key details that would be needed to implement it.

In our MACRA NPRM comments, we urged 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 are very disappointed that CMS finalized a policy that again 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.

Congress recognized the principle from the ACO authorizing statute that one of the purposes of creating ACOs is to "encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery." That investment—the cost of switching to a fundamentally different approach to patient care—is in and of itself a substantial risk. ACOs incur these costs with the goal of earning shared savings payments; therefore, ACOs consider and account for their investment costs as risk inherent in MSSP participation. These 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 to qualify as Advanced APMs. Specifically, we urge CMS to develop a mechanism to account for the substantial investments ACOs make in order to participate, including those related to clinical and care management, health IT/population analytics/reporting, and ACO management and administration.

Nominal Risk Thresholds Required for Advanced APMs

Key Comments:

- **NAACOS appreciates CMS simplifying and lowering the nominal risk thresholds and introducing a revenue-based threshold.**
- **NAACOS urges CMS to remove Part A revenue from the revenue-based threshold and maintain the 8 percent threshold at least through 2020.**

We support CMS's modified approach to establishing nominal risk thresholds, by simplifying and lowering the required amounts necessary to meet nominal risk standards. However, we urge CMS to go farther and 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 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 notes that CMS has long defined "significant" impact as 3 percent of physician revenue. We urge CMS to revise this threshold by lowering it to 1 percent.

While we strongly support CMS finalizing 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 final policy establishes the revenue-based threshold on 8 percent of an APM Entity's Medicare Part A and B revenue, but 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 APM 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 finalize a revenue-based threshold of 8 percent, but we strongly recommend the agency remove Part A revenue and only include an APM Entity's Part B revenue.

The final MACRA rule with comment period states that 8 percent is only the standard for performance periods 2017 and 2018. In the preamble, CMS states its intention to increase the revenue-based nominal amount standard for the third and subsequent performance periods, and seeks comment on: (1) setting the revenue-based standard for 2019 and later at up to 15 percent of revenue; or (2) setting the revenue-based standard at 10 percent so long as risk is at least equal to 1.5 percent of expected expenditures for which an APM entity is responsible under an APM.

In the MACRA statute, Congress has already 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 Qualified APM Professional (QP) status. An APM Entity that is accountable for losses of up to 8 percent of 75 percent of its total Parts A and B revenues 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 revenues 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 will incur as they transition to APMs. Dramatically increasing the revenue-based threshold in 2019 or beyond would likely discourage participation in Advanced APMs. We strongly urge CMS to preserve stability and predictability for APMs by maintaining the 8 percent threshold for 2019 and future years.

Calculation and Payment of APM Bonus

Key Comments:

- **NAACOS urges CMS to reverse its final policy and pay the Advanced APM bonus directly to the APM Entity just as CMS pays the ACO for shared savings under the MSSP rather than directly paying the participant TINs within the ACO.**
- **NAACOS recommends CMS change its final policy and include ACO shared savings payments as supplemental service payments in the calculation of the APM incentive payment amount.**

CMS finalized a policy to pay the Advanced APM bonus to QPs who are identified by their unique TIN/NPI combination as participants in an Advanced APM Entity on a CMS maintained list. The agency will pay the APM Incentive to the TIN that is affiliated with the Advanced APM Entity through which the eligible clinician met the threshold during the QP performance period. Therefore, for ACOs that

have multiple participant TINs the bonuses will be paid to the participant TINs rather than to the TIN of the ACO.

NAACOS strongly recommends CMS change this policy and pay the Advanced APM bonus to the APM Entity just as CMS pays the ACO for shared savings under the MSSP rather than directly paying the participant TINs within the ACO. This approach would allow ACOs to allocate incentive payments fairly and accurately in accordance with the shared risk for individual eligible clinicians in the APM Entity.

CMS finalized that it will only include supplemental service payments in the calculation of the APM Incentive Payment amount if they meet certain criteria. The approach for identifying supplemental payments to be included in the Advanced APM bonus calculation ignores the goals of population-based payment models that strive to *decrease* traditional spending through care coordination and alternative approaches to providing care. Therefore, ACO providers work to lower their spending, which under CMS's Advanced APM bonus calculation, penalizes them by also lowering the amount of their bonus. We urge CMS to include ACO shared savings payments as supplemental service payments in the calculation of the APM incentive payment amount.

QPs and Partial QPs

Key Comments:

- **NAACOS appreciates CMS's revised QP determination approach and timing which allows providers that join MSSP ACOs during the performance year to be eligible to qualify as QPs.**
- **NAACOS supports CMS's final policy that allows Partial QPs to decide whether they want to be evaluated under MIPS, a decision made at the APM Entity level which reinforces the role of the APM Entity as a collective body.**
- **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.**

Additional comments: We appreciate CMS's consideration of stakeholder feedback about the timing of QP determinations and the modification in the final rule to use three dates throughout the performance period to allow new providers that join a MSSP ACO to be eligible to be QPs for that year. This policy strikes a good balance between earlier notification and the reality that providers move to new organizations as a matter of routine organizational turnover. We also support CMS's policies to make QP determinations at the APM Entity level and to allow Partial QPs the option to participate in MIPS.

Currently, there is approximately 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 2017 in mid-June 2016). If a physician joins the ACO July 1, 2016, he or she would be ineligible to receive an Advanced APM bonus until 2020. A three-and-a-half-year delay for a provider actively engaged in an 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.

Advanced APM Certified Electronic Health Record Technology (CEHRT) Requirements

Key Comments:

- **NAACOS urges CMS to clarify as soon as possible any actions that Next Generation ACOs must take to ensure they continue to meet Advanced APM CEHRT Requirements.**
- **NAACOS reiterates concerns about required use of specific versions of EHRs and urges flexibility to allow ACOs to meet CEHRT use requirements.**

Additional comments: CMS has indicated that the agency's Next Generation team will provide more information on how CMS will collect and measure whether Next Generation ACOs have at least 50 percent of their eligible clinicians using CEHRT. While the Next Generation ACO model meets the Advanced APM CEHRT criterion by having CEHRT use requirements in place, these requirements have not yet been updated to address the end of Meaningful Use and the start of Advancing Care Information (ACI). We urge swift clarification so that Next Generation ACOs have time to understand and prepare for any new potential requirements.

NAACOS is very concerned that providers have been forced to transition to new electronic health records (EHRs) to meet government criteria which is not beneficial for providers and causes significant disruptions. An EHR is a significant purchase which requires considerable financial resources as well as many staff hours to transition to a new or upgraded system and learn how to use it. Many vendors may not be ready to meet the new criteria, leaving providers out of luck with a potentially uncertified system that would otherwise meet their needs. We urge CMS to allow the use of 2014 CEHRT at least through 2020, if not longer, depending on how many vendors are certified.

Other Payer APMs

Key Comments:

- **NAACOS urges CMS to minimize administrative burdens for providers to demonstrate their APM participation with Other Payer APMs.**
- **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.**

The MACRA statute allows APM participants beginning in the third performance year to meet the escalating QP thresholds with a combination of Medicare and Other Payer APM revenues or patients. For Other Payer APMs to meet the Advanced APM standard, the final MACRA rule with comment period requires a total risk requirement of at least 4 percent of expenditures and a marginal risk rate of at least 30 percent. There is no revenue-based risk option for Other Payer APMs. CMS seeks feedback on the Other Payer risk thresholds and how to implement requirements for Other Payer APM arrangements.

We urge CMS to align the requirements for risk across Medicare and Other Payer APMs. CMS did not finalize its proposed marginal risk rates for Medicare Advanced APMs and should therefore not do so for Other Payer APMs. Further, CMS finalized a higher loss sharing limit of 4 percent expected expenditures and did not provide a revenue-based threshold for Other Payer 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. We urge CMS to survey these payers on their common APM risk arrangements and share that information with stakeholders. Further, we see no reason that the risk thresholds for these payers should be higher or more complicated than what is required for Medicare Advanced APMs. Alignment across payers will be especially important as the

industry develops more multi-payer arrangements which align not only financial measures and metrics but also those related to other key APM criteria such as quality measures and evaluation, patient attribution, and risk adjustment. 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). Therefore, we strongly recommend that CMS establish the same financial risk requirements for Other Payer Advanced APMs that it finalized for Medicare Advanced APMs.

Track 1+ ACO Model

Key Comments:

- **NAACOS applauds CMS's plans to develop Track 1+.**
- **NAACOS urges CMS to design Track 1+ so that it meets the Advanced APM criteria under the QPP as well as to:**
    - **Establish lower Track 1+ risk levels than those required in current two-sided risk models, thus allowing Track 1+ fill a critical need for a lower risk track;**
    - **Expedite development of Track 1+ so ACOs can begin participating in 2018;**
    - **Allow ACOs to move into Track 1+ at the start of any performance year and not be required to wait until the start of their next three-year agreement period; and**
    - **Develop Track 1+ so that it is widely available to ACOs of all sizes and structures, and that participation in the model is not restricted to a few years.**

Additional comments: CMS's plans to develop Track 1+ represents an important step to ensure the long-term viability of the ACO model by introducing a new ACO track that incorporates less downside risk than what is required in existing two-sided ACO models. Track 1+ must be designed to incentivize ACOs to begin taking on risk in a manner that holds them accountable for cost and quality but does so in an appropriate way, providing a glide path to assuming risk. We applaud CMS's plans to develop Track 1+ and urge the agency to establish it so that it is widely available to ACOs of all sizes and structures and that participation in the model is not restricted to a specific number of agreement periods. We also greatly appreciate CMS's plans to develop Track 1+ as an Advanced APM starting in 2018 under the MACRA Quality Payment Program (QPP). It is imperative that CMS finalize Track 1+ in an expedited manner to ensure its availability for ACOs to begin participating in the new model in 2018, and we strongly recommend CMS release finalized Track 1+ details as soon as possible. Below are our recommendations for the key elements of Track 1+.

The Need to Create Track 1+

As developing organizations, many ACOs face challenges achieving success, as defined by lowering spending relative to their benchmark enough to earn shared savings. While success rates have increased each performance year and ACOs that started the program earlier have higher success rates, according to this CMS Public Use File updated on October 19, 2016, only 119 out of 392 MSSP ACOs earned shared savings in Performance Year 2015. Further, 2016 was the first year when ACOs renewed three-year agreement periods, and only two-thirds of 2012/2013 ACOs remained in the program and renewed their agreements in 2016. To ensure more ACOs can succeed and will thus remain in the program, CMS must continue to make program enhancements to ensure the long-term viability of the Medicare ACO Model.

Since inception of the MSSP, CMS has emphasized the need for ACOs to assume downside financial risk for their patient population as the best way to incentivize ACOs to reduce unnecessary utilization and lower the growth rate of Medicare expenditures. However, as a portion of total 2016 Medicare ACOs,

including those in the MSSP, Next Generation and Pioneer Models, those in two-sided risk models only represent slightly more than 10 percent of Medicare ACOs. Track 1 remains by far the most popular option, with 95 percent of MSSP ACOs in Track 1 this year, and from 2012 to 2016 the growth rate for Track 1 has been four times the growth rate of two-sided models. However, ACOs may only remain in Track 1 for two agreement periods before having to move to a two-sided risk model or drop out of the program. Further, the disproportionate emphasis on the goal of reducing costs overshadows the equally important goal of improving quality that the ACO model offers which, in the long run, will benefit both patients and the Medicare program generally.

With growing calls for ACOs to take on risk, it is important to recognize that ACOs remain in Track 1 in large part due to the high levels of risk required in the two-sided models. The current two-sided models (MSSP Track 2, 3 and the Next Generation ACO Model) include risk levels that are significantly higher than what the vast majority of ACOs can bear and therefore are not viable for most ACOs. The decision to take on risk is at the heart of an ACO's choice about which model to select and having to potentially pay millions of dollars to Medicare is simply not practical nor feasible for most of these organizations. This type of risk necessitates that ACOs have considerable financial backing. Many ACOs are unable to access investor capital and face many barriers to obtaining sizeable credit. Without large enough assets to secure loans, many physician owners are left having to personally guarantee debts and obligations. Basing risk on total cost of care creates situations where physicians could be responsible for repaying a substantial amount, if not all, of their Medicare income for a particular year.

The challenges of taking on risk are often exacerbated for those in rural areas and safety-net providers, which care for some of the most vulnerable patient populations. These providers tend to have even fewer resources and may struggle to come up with start-up and investment costs, let alone be in a position to assume down-side risk. Even the promise of higher shared savings rates or the ability to utilize waivers afforded to two-sided ACOs is not enough to overcome the barriers to assuming considerable financial risk. Further, ACOs are in the business of delivering care and are not necessarily well equipped to take on what is essentially actuarial risk more typical of a health insurance company. Finally, while a slight majority of ACOs are physician owned, many others share ownership and financial responsibility with hospitals, which often have the same concerns about such high risk.

Based on these realities, it is critical that CMS develop Track 1+, which would provide a much-needed option that enhances accountability for costs but does so in a manner more appropriate for ACOs. Below are our specific recommendations for establishing Track 1+, and we look forward to working with CMS on these and other key areas of the model's design.

Comments on Information Included in the MACRA Final Rule with Comment Period

Qualification of Track 1+ as an Advanced APM

In the final MACRA rule with comment period, CMS states that it would design Track 1+ with sufficient financial and nominal risk in order to be an Advanced APM. In passing MACRA, Congress clearly intended to create an accelerated pathway for physicians to move from fee-for-service to APMs, with a particular emphasis on APMs that include accountability for quality and cost. Track 1+ is one example of the type of model Congress intended, and we therefore feel very strongly that CMS should develop Track 1+ as an Advanced APM. Track 1+ represents an important option for Track 1 ACOs to transition to a model that includes risk, and Track 1+ will incentivize new providers to form ACOs, thus bolstering the growth and success of the Medicare ACO Model. The Advanced APM bonus and higher payment rates in 2026 and beyond will be key determinants for many ACOs to take on risk

under Track 1+. ACOs are on the cusp of so much potential, and we feel that creating Track 1+ as an Advanced APM will benefit ACOs today and moving into the future.

We strongly support CMS finalizing details of Track 1+ so that this model meets the Advanced APM criteria and look forward to working with CMS on its development so that Track 1+ is available beginning with the 2018 performance year.

Track 1+ Risk Levels

CMS explains that Track 1+ would test a payment model that incorporates more limited downside risk than what is currently required in existing two-sided ACO models. Specifically, the loss sharing limit would be related to the thresholds CMS finalized for Advanced APMs. Therefore, should losses occur, the total annual amount that a Track 1+ ACO would potentially owe CMS or forego would be equal to at least:

1. For performance periods in 2017 and 2018, 8 percent of the average estimated total Medicare Parts A and B revenues of the ACO (the "revenue-based standard"); or
2. For all performance periods, 3 percent of the expected expenditures for which an ACO is responsible under the APM (the "benchmark-based standard").

We urge CMS to finalize a Track 1+ risk structure and level that equals the minimum amounts of risk required under the final Advanced APM criteria, thus allowing Track 1+ to qualify as an Advanced APM. We urge CMS to maintain the same revenue-based threshold for the duration of the first three-year Track 1+ agreement period to ensure stability for program participants. Please refer to our additional comments on the Advanced APM risk levels in the previous section.

Benchmarks for Existing ACOs That Move to Track 1+

CMS states that Track 1 ACOs that move into Track 1+ would have their benchmark rebased using CMS's new benchmarking methodology which incorporates a component of regional expenditure data into the rebased benchmark. We strongly support CMS applying the new rebased benchmarking methodology to current ACOs that move into Track 1+. Earlier this year we sent a comment letter generally supporting CMS's proposal to revise the benchmarking methodology to incorporate a component of regional expenditure data into rebased ACO benchmarks, a policy which CMS subsequently finalized. In that letter, we strongly recommended CMS allow ACOs flexibility and provide options for moving to the new rebased benchmarking methodology. Based on the final policy, ACOs that began the MSSP in 2012 and 2013 must wait until 2019 to have their benchmark rebased using the new methodology, and many of these ACOs would like to move to the new methodology sooner. Therefore, we support CMS applying the new rebased benchmarking methodology to current ACOs that move into Track 1+ and recommend CMS finalize this policy.

Track 1+ Availability

Like other ACO models, CMS states that Track 1+ would be voluntary and available to new ACOs and those currently in Track 1, but ACOs currently in MSSP Tracks 2 and 3 or the Next Generation or Pioneer ACO Models would not be eligible for Track 1+. CMS further explains that Track 1+ would be designed to encourage a progression to two-sided risk and is envisioned as an on-ramp to other two-sided ACO models.

We strongly support Track 1+ being a voluntary model available to new ACOs and those in Track 1, but we also urge CMS to also make this opportunity available to ACOs currently in MSSP Tracks 2 and 3, as well as to those in the Pioneer and Next Generation Models. ACOs in these tracks/models have demonstrated a clear commitment to value-based payment models and to assuming financial

accountability. However, some of these ACOs may not be successful and could face repayment of losses greater than they anticipated. Should they conclude they are unable to continue in their current ACO track/model, allowing them to participate in Track 1+ would be more beneficial for the ACOs and Medicare rather than requiring them to remain in an unsustainable situation. Faced with this dilemma, many ACOs would likely drop out of the program. Therefore, allowing them to move into Track 1+ would be a better option and would not penalize them for their early commitment to a two-sided risk model. We strongly recommend that CMS allow all current and new ACOs to participate in Track 1+. We also request that ACOs be able to move into Track 1+ at the start of any performance year and not be required to wait until the start of their next three-year agreement period.

Comments on Track 1+ Elements Not Addressed in the MACRA Final Rule with Comment Period

In addition to our comments in the previous section on Track 1+ elements discussed in the final MACRA rule with comment period, this section of the letter includes our recommendations for other Track 1+ program elements and requirements which we urge CMS to incorporate into the design of Track 1+.

ACO Eligibility for Track 1+ Participation

We strongly urge CMS to allow all ACOs to be eligible to participate in Track 1+ and to not restrict participation based on ACO size or composition (e.g., only physician-led ACOs or small ACOs). Such participation limits would unfairly disadvantage ACOs with hospital participants, those from large health systems or health-plan affiliated ACOs. While CMS has stated its belief that certain types of ACOs (i.e., larger ACOs, those with hospital participants or those affiliated with health plans) are better equipped to take on downside risk, we disagree with this assertion. The financial position and backing of a particular ACO as well as the ability to assume risk can depend on a variety of factors, such as local market dynamics, culture, leadership, financial status, and the resources required to address social determinants of health that influence care and outcomes for patients with complex needs. These factors may or may not be related to the type of ACO. Therefore, we urge CMS to make Track 1+ broadly available to all types of ACOs.

We also strongly recommend that CMS allow current ACOs to move into Track 1+ at the start of any performance year and not be required to wait until the beginning of their next three-year agreement period. Currently, ACOs may only switch MSSP tracks at the start of a new three-year agreement, and once that period begins they are locked into their decision until their next agreement. As ACOs consider their options for the future, it will be essential for CMS to adopt a more flexible policy to allow ACOs to move into two-sided risk models such as Track 1+ earlier than the start of their next agreement period. Given that the 5 percent Advanced APM bonus is only in effect for a few years with the last performance year of 2022, it would be incredibly unfair to lock ACOs into decisions for years to come, especially when new options such as Track 1+ become available.

Length of Agreement Period and Long-Term Participation

We recommend CMS use three-year agreement periods for Track 1+, which is the same as other MSSP tracks and maintains consistency across the MSSP. We urge CMS to allow ACOs to remain in Track 1+ for an unlimited number of agreement periods. While CMS notes that the agency envisions Track 1+ as an on-ramp to other two-sided ACO models, many ACOs will likely never be able to assume the very high levels of risk in the existing two-sided models. This is demonstrated by the current low levels of participation in those ACO tracks/models relative to participation in Track 1. We urge CMS to retain the current two-sided ACO tracks/models as options for ACOs that are ready to assume those levels of risk.

Developing Track 1+ creates an important glide path for assuming risk, representing an option in between Track 1 which has no downside risk and the higher risk levels included in the other two-sided ACO tracks/models. However, it is important to note that we oppose limiting Track 1+ participation to a certain number of agreement periods and forcing ACOs to take on greater risk in other models. If, as we are advocating, CMS develops Track 1+ to meet the Advanced APM risk thresholds, we see no reason that ACOs could not remain in Track 1+ indefinitely. Limiting Track 1+ participation to a certain number of agreement periods would likely result in ACOs eventually dropping out of the program rather than assuming risk they are not prepared for. Retaining ACOs in Track 1+ would benefit ACOs and Medicare by continuing to incentivize them to enhance quality of care and generate savings for themselves and the Medicare Trust Funds. Therefore, we urge CMS not to restrict Track 1+ participation to a particular number of agreement periods.

Financial Structure

Minimum Savings Rate (MSR) and Minimum Loss Rate (MLR)

The MSR/MLR are key components of the ACO model design and represent the percentages by which an ACO's actual expenditures differ from their benchmark, after which point the ACO would be eligible to earn shared savings or would be required to repay losses. As with Track 2 and 3, we urge CMS to allow Track 1+ ACOs to have a choice of a symmetrical MSR/MLR: no MSR/MLR; symmetrical MSR/MLR in 0.5 percent increments between 0.5 percent and 2.0 percent; symmetrical MSR/MLR to vary based upon number of assigned beneficiaries (as in Track 1).

Shared Savings Rate

As with other MSSP tracks, we recommend Track 1+ have first dollar savings after surpassing the ACO's MSR. As with Track 2, we recommend a specific shared savings rate starting at 60 percent. However, for all ACO tracks and models – including Track 1+ – we recommend the shared savings rate increase based on quality performance/improvement. Specifically, for Track 1+, we urge CMS to allow the shared savings rate to increase from 60 percent up to 70 percent based on quality performance/improvement.

Shared Loss Rate

We recommend CMS implement a shared loss rate of 30 percent for Track 1+. This rate is essential to defining potential losses as it determines what portion of the losses the ACO would have to pay back, should its losses meet or exceed the MLR. In the proposed MACRA rule, CMS proposed that for an APM to meet the nominal amount standard the specific level of marginal risk must be at least 30 percent of losses in excess of expected expenditures. While the agency did not finalize any required shared loss rate for an Advanced APM, its proposal illustrates that the agency considers 30 percent sufficient to meet the nominal risk criteria, and we therefore recommend CMS finalize a 30 percent shared loss rate for Track 1+.

Performance Payment Limit

We recommend CMS implement a 15 percent performance payment limit, which is the maximum potential payment an ACO could receive and is based on total cost of care. CMS uses a 15 percent performance payment limit with Track 2 and we feel this threshold would also be appropriate for Track 1+.

Financial Benchmark in Initial and Subsequent Agreement Periods

We recommend Track 1+ utilize the same benchmarking methodology used for the other MSSP tracks. While we continue to advocate for specific changes to the existing methodology, we feel it is

appropriate to align the methodology across the MSSP. Further, we strongly recommend that existing ACOs entering into Track 1+ in 2018 should have their benchmarks rebased using the new methodology, which incorporates a component of regional expenditures into the rebased benchmark.

Financial Mechanisms to Demonstrate Ability to Repay Losses

If they incur losses, Track 1+ ACOs should have a variety of acceptable repayment mechanisms, including those currently permitted by CMS (e.g., placing funds in escrow, obtaining a surety bond, establishing a line of credit, or establishing a combination of the approved repayment mechanisms). We also urge CMS to restore reinsurance as a qualifying repayment mechanism. Reinsurance was a permissible repayment mechanism for MSSP ACOs until CMS removed this option in the June 2015 final MSSP rule. The agency's rationale for doing so was that few ACOs were using this option. However, we question that logic especially considering how few two-sided ACOs there were at that time. Further, despite limited initial use of reinsurance for demonstrating ability to repay losses to CMS, reinsurance continues to be an option which some ACOs pursue separate from their CMS obligations. We see no harm in CMS reinstating reinsurance as an option, and we urge CMS to do so for all two-sided ACO tracks/models, including Track 1+. As discussed in more detail in the previous section, we also urge CMS to develop a new optional mechanism to repay losses by reducing the Medicare Physician Fee Schedule payment rates of an ACO's participant TINs/NPIs in future years.

Beneficiaries and Risk Adjustment

Minimum Number of Beneficiaries

We recommend CMS implement a minimum threshold of 5,000 beneficiaries for Track 1+, which is consistent with the other MSSP tracks but is lower than the 10,000 (or 7,500 for rural ACOs) beneficiary threshold used in the Next Generation ACO model. We also recommend that for Track 1+ CMS implement the same policy it recently finalized in the final 2017 Medicare Physician Fee Schedule for MSSP Track 2 and 3 ACOs that fall below 5,000 beneficiaries at the time of financial reconciliation. Under that policy, Track 2 and 3 ACOs that choose a non-variable MSR/MLR at the start of the agreement period but subsequently fall below 5,000 assigned beneficiaries at the time of financial reconciliation remain eligible for shared savings (or losses). Further, their MSR/MLR used for financial reconciliation remains the same as what the ACO selected at the start of the agreement period and does not change as a result of the population falling below 5,000. If the ACO selected a variable MSR/MLR based on its number of assigned beneficiaries, CMS will use the same approach it currently uses for Track 1 ACOs in this situation, which relies on an expanded sliding scale for the MSR/MLR to match the number of assigned beneficiaries, should that population fall below 5,000.

Beneficiary Assignment

We urge CMS to provide Track 1+ ACOs, as well as ACOs in all MSSP Tracks, the option of using the Track 1 and 2 assignment methodology (i.e., preliminary prospective assignment with retrospective reconciliation) or using the method used for Track 3 (i.e., prospective assignment). We strongly support allowing ACOs to have the option of choosing prospective or retrospective assignment. Certain ACOs, such as a small ACO worried about dropping below the 5,000 beneficiary threshold, may favor a model where the ACO can add beneficiaries throughout the year, and would thus prefer the retrospective assignment model. However, other ACOs would likely prefer a prospective model, which would help them stabilize their beneficiary population and thus avoid volatile benchmark changes. Further, more advanced ACOs typically employ data analysis and beneficiary engagement techniques from the start of the performance period on a population for whom they know they are responsible. For these reasons, we strongly recommend that CMS provide Track 1+ ACOs, and all MSSP ACOs, the option of choosing either retrospective or prospective assignment.

Voluntary Beneficiary Alignment

In the recent final 2017 Medicare Physician Fee Schedule, CMS finalized a modification to the MSSP beneficiary assignment algorithm to allow beneficiaries to designate an ACO professional as responsible for their overall care. We are very pleased that CMS finalized the use of voluntary alignment which will allow beneficiary designations to result in the beneficiary being assigned to the designated provider as long as certain criteria are met. Providing beneficiaries with the opportunity to voluntarily align with an ACO balances the important considerations of beneficiaries' freedom to choose their providers with ACOs' interest in reducing patient churn and having a more defined and stable beneficiary population identified up front. This, in turn, allows ACOs to better target their efforts to manage and coordinate care for beneficiaries for whose care they will ultimately be held accountable. In addition, allowing beneficiaries to attest to the provider they want to manage their care may help increase beneficiary engagement in that care. CMS finalized this policy for all MSSP tracks, and we recommend this be applied to Track 1+ as well.

Adjustments for Beneficiary Health Status and Demographic Changes

We have previously expressed concerns about CMS's use of different methods for updating risk adjustment for newly and continuously assigned beneficiaries, the latter of which are prohibited from increases to their risk adjustment scores based on health status but may have decreases to risk scores. It is unreasonable to assume an ACO, however effective, can manage a population such that patient conditions never worsen over time and it never carries a higher disease burden. For Track 1+, and all MSSP tracks, we urge CMS to allow risk scores to increase year-over-year within an agreement period for the continuously assigned. Should CMS require limits to risk score changes, we would support a 3 percent cap on average risk score increases or decreases, which is the approach used for the Next Generation ACO Model. Therefore, we urge CMS to address the flaws with the risk adjustment methodology for Track 1+ as well as more broadly in the MSSP by allowing risk scores to increase for continuously assigned beneficiaries.

Quality and Waivers

Quality Reporting Requirements

We support CMS implementing the same quality reporting requirements for Track 1+ as with ACOs in other MSSP tracks, including reporting via the CMS Web Interface, evaluation on claims-based measures and patient satisfaction. MSSP ACOs demonstrate positive results with quality, and we see no reason for using different measures or requirements for Track 1+.

However, we strongly urge CMS to allow quality performance and quality improvement to increase the percent of shared savings a Track 1+ ACO may earn, from 60 to 70 percent. Under current MSSP rules, an ACO that achieves CMS's established quality performance levels is not rewarded and is merely prevented from forfeiting the shared savings payments it has earned. In contrast, Medicare Advantage (MA) plans are rewarded with higher benchmarks for higher quality, which leads to an asymmetry between MA plans and ACOs. As noted by the Medicare Payment Advisory Commission (MedPAC) in their February 2, 2015 letter to CMS, "Otherwise, the ACO with top quality performance would end up with a lower benchmark than an MA plan in the same market with top quality performance. That situation could be seen as inequitable for the ACO."

Many efforts to improve quality of care consume ACO resources and increase spending relative to the ACO's financial benchmark in the short term, even if they decrease Medicare spending over the long term. The more an ACO strives to improve quality performance, the more it often needs to spend.

ACOs that make large investments to improve quality performance may be less able to keep spending below their benchmarks as a direct result of their increased investment in quality. We urge CMS to properly reward Track 1+ ACOs, as well as all MSSP ACOs, for high quality. It is important to recognize high quality performance compared to established measure thresholds as well as to recognize – and reward – quality *improvement* relative to an ACO's previous performance. Therefore*, to emphasize and reward above average quality performance or improvement, we urge CMS to provide on a sliding scale up to 10 percentage points of additional shared savings to Track 1+ ACOs, from 60 to 70 percent.*

Compliance and Payment Waivers

We urge CMS to use the full scope of the combined authority granted by Congress under the Affordable Care Act to issue waivers of the applicable fraud and abuse laws, similar to those it has issued for ACOs in the Pioneer, MSSP, and Next Generation programs. Specifically, CMS should issue:

- An ACO "pre-participation" waiver of the Stark and Anti-kickback statutes to protect ACO-related start-up arrangements in anticipation of participating in Track 1+;
- An ACO participation waiver of the Stark and Anti-kickback statutes that applies broadly to ACO-related arrangements during the term of the participation agreement;
- A shared savings distributions waiver of the Stark and Anti-kickback statutes that applies to distributions and uses of any earned shared savings payments or internal costs savings;
- A waiver of the Anti-kickback statute for ACO arrangements that implicate the Stark law and satisfy the requirements of an existing exception; and
- A waiver of the Beneficiary Inducements civil monetary penalty and the Anti-kickback statute for medically related incentives offered by ACOs, ACO participants, or ACO providers/suppliers to assigned beneficiaries to encourage preventive care and compliance with treatment regimes.

These waivers are critical to removing legal and regulatory barriers that inhibit providers from working together to provide better-coordinated, high quality care. We also strongly encourage CMS to make available to all Medicare ACOs, including Track 1+, waivers related to the following:

- **Hospital discharge planning requirements** that prohibit hospitals from specifying or otherwise limiting the providers who may provide post-hospital services;
- **The skilled nursing facility (SNF) three-day stay rule,** which requires Medicare beneficiaries to have a prior inpatient stay of no fewer than three consecutive days in order to be eligible for Medicare coverage of inpatient SNF care;
- **Medicare requirements for payment of telehealth services,** such as limitations on the geographic area and provider setting in which these services may be received;
- **Homebound requirements for home health,** which mandate that a Medicare beneficiary be confined to the home to receive coverage for home health services; and
- **Medicare primary care co-payments**, which would reduce or eliminate cost-sharing otherwise applicable under Medicare Part B for some or all primary care services furnished by health care professionals within the network of the ACO.

Waiving these payment regulations is essential so that ACOs can effectively coordinate care and ensure that it is provided in the right place at the right time. These waivers would provide ACOs with valuable tools to increase quality and reduce unnecessary costs and should be available to advance the success of all ACOs, including those in Track 1+. Further, CMS should implement the waivers in a manner that is not prohibitively burdensome to ACOs that utilize them. CMS should ensure that the waivers are easily

accessible to ACOs and should rely on the ACOs' existing cost and quality metrics to ensure that ACOs continue to provide high-quality, appropriate care to their ACO populations.

MIPS Recommendations

MIPS Scoring Standard for APMs

NAACOS is pleased to see CMS's recognition of the efforts by ACOs to create a MIPS scoring standard for APMs that do not meet Qualified Participant (QP) thresholds for Advanced APM status. Allowing ACOs to continue to focus on their MSSP goals and leverage the work they have already done to improve quality, lower costs, and place a greater focus on population health and lowering the total cost of care will best serve both ACOs and their patients. Although CMS has finalized a number of policies providing favorable benefits to ACOs that will be evaluated under the MIPS APM Scoring Standard, there are a number of areas where ACOs will need further guidance on how specific MIPS policies will apply. Particularly given the new intersection of ACO program quality reporting and the MIPS requirements, these clarifications will be critical for ensuring ACO success in both the MSSP, NGACO, and MIPS programs. The following are our comments on the policies finalized for the MIPS APM Scoring Standard as they apply to ACOs.

MIPS APMs and APM Identifiers

Key Comment:

- **NAACOS supports CMS's final policy providing ACOs with one ACO Entity level score in MIPS.**

Additional comments: NAACOS supports the final policy providing ACOs with one ACO Entity level score in MIPS. This approach aligns with ACO program goals to focus collectively on care transformation activities as an ACO Entity. We appreciate CMS acknowledging the necessity of maintaining one ACO score in each performance category as well as the overall Composite Performance Score.

Quality Performance Category

Key Comments:

- **NAACOS urges CMS to clarify the total available points for ACOs in the quality performance category.**
- **NAACOS recommends changes to MIPS quality benchmarking methodologies to make more accurate comparisons. Specifically, we urge CMS to develop a common mean that could be used for all reporting methods, but create a separate standard deviation for each reporting method based on its average sample size and relative variation.**

Additional comments: We support CMS's finalized policy allowing quality measure data submitted through the CMS Web Interface by ACOs participating in the MSSP and Next Generation ACO Models to also be used to evaluate ACO performance for the MIPS quality performance category. By allowing ACOs to continue to focus on their current quality improvement efforts through the MSSP and Next Generation ACO Models, CMS will encourage continued participation in these programs and reduce unnecessary and duplicative quality reporting. We also thank CMS for clarifying MSSP and Next Generation ACOs will not be evaluated on population measures under MIPS, which would have

conflicted with existing ACO quality metrics. However, NAACOS seeks a number of changes and clarifications regarding the quality performance category.

First, CMS must clarify the total available points for ACOs in the quality performance category. Currently, it is not clear if the three measures without a MIPS benchmark would still be scored using the global floor of three points for each measure. It is also not clear what the maximum bonus opportunity is for ACOs under the quality performance category. Scoring methods must be transparent and made available to ACOs prior to the 2017 performance period so ACOs can properly evaluate and plan for the upcoming performance year.

Additionally, while we appreciate CMS's final policy to compare ACOs to other Web Interface reporters in MIPS, we urge the agency to make further modifications to the methodology for devising quality benchmarks to more accurately compare performance. Specifically, NAACOS recommends CMS develop a common mean that could be used for all reporting methods, but create a separate standard deviation for each reporting method based on its average sample size and relative variation.

Clinical Practice Improvement Activities (CPIA) Performance Category

Key Comments:

- **NAACOS supports the final policy to provide ACOs with full credit in the CPIA performance category in recognition of ACOs' ongoing work on performance improvement inherent in the MSSP and Next Generation Models. We ask CMS to ensure there are no additional documentation or reporting burdens placed on ACOs through any subsequent registration or attestation processes.**
- **NAACOS reiterates our request that CMS reweight the CPIA category to 25 percent and hold the ACI performance category weight at 25 percent for ACOs.**

Additional comments: NAACOS is pleased with CMS's final policy to provide ACOs with full credit in the CPIA performance category in recognition of ACOs' ongoing work on performance improvement inherent in the MSSP and Next Generation Models. It is critical that CMS continue to acknowledge and honor the ongoing efforts of ACOs in their respective programs when evaluating these entities under MIPS. We ask that CMS ensure there are no additional documentation or reporting burdens placed on ACOs through any subsequent attestation or registration processes to evaluate the CPIA performance category for ACOs.

We also reiterate our previous request that CMS reweight the CPIA category to 25 percent and hold the ACI performance category weight at 25 percent for ACOs. Since CMS is already using MSSP and Center for Medicare and Medicaid Innovation authorities [Section 1899(f) of the Act and Section 1115A(d)(1) of the Act] to waive specific statutory provisions related to MIPS reporting and scoring, we feel this reweighting would be appropriate and would more accurately reflect how an ACO should be measured in MIPS, should they not meet QP or Advanced APM status. This also creates a more even distribution of the three remaining categories MIPS APMs will be scored on under the MIPS APM Scoring Standard.

Advancing Care Information (ACI) Performance Category

Key Comments:

- **NAACOS requests clarification on the ACI exemptions as they will pertain to eligible clinicians (ECs) in ACOs. Specifically, we urge CMS to clarify that ECs in ACOs will be provided the same exemptions from ACI scoring as those not in ACOs.**
- **NAACOS urges CMS to release more details regarding how ACI group reporting will be accomplished for ACOs reporting ACI.**
- **NAACOS urges CMS to publish updated measures specifications for the revised ACO-11 measure promptly so ACOs can make the necessary operational changes to be able to report this measure, which will be used for evaluation in both the MSSP and MIPS programs.**

Additional comments: ACOs have a number of concerns related to the ACI performance category and its intersection with the MSSP requirements for reporting of measure ACO-11. We ask CMS to clarify the issues outlined below swiftly in order for ACOs to prepare for the start of the 2017 performance year, which is rapidly approaching. Additionally, given the new intersection of the MSSP and MIPS programs, CMS must provide more ACO-specific guidance on ACI MIPS requirements going forward to avoid confusion in these areas.

ACI exemptions for ACO ECs

In the final rule CMS states that in general, MIPS ECs will be evaluated under all four of the MIPS performance categories, including MIPS ECs who were not previously eligible for the EHR Incentive Program incentive payments such as physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and hospital-based EPs as defined in section 1848(o)(1)(C)(ii) of the Act. However, CMS has finalized a policy whereby CMS will reweight the ACI performance category to zero in the MIPS final score for such categories of clinicians where the measures finalized for this performance category may not be available or applicable. CMS notes "our assumption remains that MIPS eligible clinicians who are determined hospital-based do not have sufficient advancing care information measures applicable to them, and thus we will reweight the advancing care information performance category to zero percent of the MIPS final score for the MIPS payment year in accordance with section 1848(q)(5)(F) of the Act."

It is not clear in the rule how these clinicians will be included or excluded from ACO MIPS evaluation for the ACI performance category. NAACOS urges CMS to clarify that ECs in ACOs will also be provided these exemptions from ACI scoring. ACOs receive one ACI performance score, as well as one overall composite performance score for MIPS. Therefore, it would not be possible for CMS to re-weight the performance categories for such ECs. Rather, we urge CMS to clarify that ECs meeting these exemptions under ACI would not be included in the calculation of the ACO's ACI performance score.

CMS also finalized that under MIPS, a hospital-based MIPS EC is defined as a MIPS EC who furnishes 75 percent or more of his or her covered professional services in sites of service identified by the Place of Service (POS) codes used in the HIPAA standard transaction as an inpatient hospital (POS 21), on campus outpatient hospital (POS 22), or emergency room (POS 23) setting, based on claims for a period prior to the performance period as specified by CMS. We request that for purposes of determining if an EC is hospital-based, the list of POS codes be expanded to include POS 19, off-campus outpatient hospital as well as POS 61, comprehensive inpatient rehabilitation facility, as these settings are similar to those included in CMS's current assessment of hospital-based status. Including these

additional places of service will more accurately exclude those clinicians who will not have sufficient ACI measures to report.

Exclusions for Part-time Employees

NAACOS urges CMS to exclude part-time employees of the ACO from ACI reporting requirements under the ACO Entity. Currently, if an ACO participant TIN employs a clinician part-time, this clinician would be included in the ACO's ACI reporting at the TIN level. However, if this clinician is also working for other outside organizations, it is not clear who would report that clinician's ACI information. To avoid this confusion, NAACOS recommends excluding from ACO entity ACI reporting and evaluation those clinicians working less than 500 hours for the ACO during the performance year.

ACI Reporting and Assessment for ACOs

CMS finalized a policy requiring MSSP ACO participant TINs to report ACI at the TIN-level using a group reporting method. ACO participant TIN scores will then be aggregated by CMS as a weighted average to yield one ACO entity score for the ACI performance category. Next Generation ACOs will report ACI at either the individual or TIN levels, and CMS will aggregate these scores to yield one average ACO entity score. We support CMS's final policy to provide the ACO with one ACO entity-level score for the ACI performance category; however, more details must be published regarding how group ACI reporting will work operationally, particularly for ACOs. Specifically, CMS must provide additional guidance regarding how unique patients will be counted when using the group reporting method. CMS notes their final policy will allow groups some flexibility as to the method for counting unique patients in the denominators to accommodate situations where a patient may see multiple MIPS ECs within the group, or see ECs at multiple group locations. CMS must publish additional details regarding what flexibility will be provided in these circumstances when practices aggregate data for group reporting and evaluation. CMS must allow for a simple group reporting and attestation process for ACO TINs to reduce administrative burdens that may be associated with this reporting structure.

Impact on Existing Meaningful Use Requirement in MSSP

As stated above, CMS must work to publish updated measures specifications for the revised ACO-11 measure promptly so ACOs can make the necessary operational changes to be able to report this measure which will be used for evaluation in both the MSSP and MIPS programs. Particularly, it will be important for CMS to further explain how exemptions will be handled. Additionally, CMS will need to provide more details regarding aggregating data for the purposes of having the ACO participant TIN report ACI through the required group reporting as detailed in this comment letter. Lastly, CMS must clarify that although ACO-11 is a pay-for-reporting measure only for the purposes of the MSSP, ACOs will also still be required to report ACI requirements under MIPS for the purposes of being evaluated under the MIPS APM Scoring Standard.

Application of MIPS APM Payment Adjustments

Key Comment:

- **NAACOS urges CMS to swiftly finalize a policy whereby MIPS APM payment adjustments will not be counted as benchmark expenditures for purposes of evaluation under ACO programs.**

Additional comments: NAACOS supports CMS's final policy to apply the same MIPS payment adjustment to all ECs in the ACO. However, we urge CMS to make the determination that it is not

appropriate to include MIPS payment adjustments in ACO benchmarks. CMS states it is outside the scope of the final rule with comment period to make a single determination with respect to the use of MIPS payment adjustments in APM benchmarking. We feel this issue is relevant to the QPP as well as the individual APM programs, and should therefore be addressed immediately. Not addressing this issue will create uncertainty and serve as a disincentive to the ACOs. Those ACOs not qualifying for AAPM status would be further punished by a policy where CMS would count MIPS payment adjustments as ACO expenditures. Section 1833(z)(1)(C) of the Act states that the APM Incentive Payment shall not be taken into account for purposes of determining actual expenditures under an APM and for purposes of determining or rebasing any benchmarks used under the APM. NAACOS urges CMS to make the same determination for MIPS payment adjustments. Including these payments as expenditures would cause conflicting program goals for those ACOs who are already at a disadvantage for not having met AAPM status and/or QP thresholds and thereby discourage their participation in the MSSP and Next Generation ACO Models.

Conclusion

The framework for MIPS and APMs 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, integrated care designed to benefit patients, and reduce unnecessary costs and utilization. We urge CMS to consider the feedback included in this letter and thank you for your consideration of our comments.

Sincerely,

Clif Gaus
President and CEO