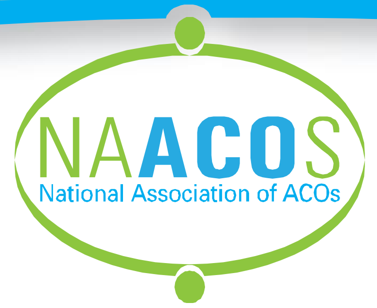

September 23, 2020

The Honorable 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, D.C. 20201

Re: (CMS-1734-P) Medicare Program: CY 2021 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements

Dear Administrator Verma:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the proposed rule, *Medicare Program; CY 2021 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements*.

NAACOS is the largest association of accountable care organizations (ACOs), representing more than 7.1 million beneficiary lives through more than 360 Medicare Shared Savings Program (MSSP), the Next Generation ACO Model, and commercial ACOs. NAACOS is an ACO member-led and member-owned nonprofit that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health, patient outcomes, and healthcare cost efficiency. We are pleased to provide our detailed comments below on the proposals found in the 2021 Medicare Physician Fee Schedule rule.

Summary of key recommendations:

MSSP Proposals

- **Finalize a policy to provide ACOs with the higher of their 2019 or 2020 quality scores in 2020 due to the impact of COVID-19, and make similar changes for 2021 as CMS continues to evaluate the impact of the pandemic in the coming year.**
- **Finalize proposals to provide automatic full points for each of the CAHPS survey measures within the patient/caregiver experience domain for ACOs in PY 2020.**
- **Do not finalize proposals to change the way ACOs are measured on and report quality measures. Instead, we urge CMS to work with NAACOS and other stakeholders to make changes to the current quality measure performance evaluation criteria and measure set for ACOs to further refine the measures and criteria as appropriate for a group of providers who are responsible for total cost of care for the populations they serve.**

- **Do not reduce the number of clinical quality measures for ACOs to three measures. While NAACOS supports reducing reporting burdens and efforts to eliminate low value measures, these proposals go too far by reducing the number of clinical quality measures to a mere three measures. CMS should work with stakeholders to identify the most appropriate set of measures for ACOs.**
- **Do not discontinue the use of the Web Interface as a quality reporting mechanism for MSSP and MIPS. Instead, CMS should maintain the Web Interface as an option as they gradually include additional reporting options for ACOs in the future.**
- **Implement alternative policies such as reverting all quality measures to pay-for-reporting or providing ACOs with historical quality performance scores for the 2021 performance year, as CMS continues to assess the ongoing impact of COVID-19.**
- **Update the definition of primary care codes used for MSSP assignment and ensure that patients are attributed to providers from whom they receive their primary care services.**
- **Finalize the proposal to Allow ACOs to lower their repayment mechanism amount if the recalculated amount for a new agreement period/year would be less than their current amount.**

Medicare Physician Fee Schedule Proposals

- **Continue the agency's work to modernize E/M codes and payment to support the delivery of higher quality, lower cost patient care.**
- **Finalize CMS proposals to maintain relativity with the increased office/outpatient E/M values by revaluing certain services and code sets that include, rely upon, or are analogous to office/outpatient E/M visits.**
- **Use CMS's statutory authority to allow all ACOs, regardless of risk level or choice of attribution, the freedom to use telehealth in broader circumstances. Enacting these changes would achieve a dual purpose of expanding the reach of telehealth, with the access to care and quality improvement it brings, along with enticing more providers to join value-based payment models like ACOs.**
- **Create new, audio-only telehealth codes but pay these new services less than that of video-based visits because they lack the same clinical meaningfulness.**
- **Count diagnoses obtained from audio-only telehealth services for risk adjustment purposes.**
- **Create more Remote Physiologic Monitoring (RPM) codes to cover monitoring periods less than 16 days but be careful that monitoring is clinically meaningful.**

Quality Payment Program (QPP) Proposals

- **Finalize the proposal to exclude beneficiaries who are prospectively attributed to an APM entity from the attribution-eligible beneficiary count for other APM entities where the beneficiary is ineligible.**
- **Finalize the proposal to add a targeted review process for QP determinations but expand the opportunity to allow for meaningful reviews of QP determinations.**
- **Do not finalize CMS proposed clarification and instead honor previous language and base the Advanced APM bonus on aggregate allowed amounts, not the lesser paid amounts.**
- **Finalize the proposal to not move forward with the MIPS Value Pathways approach in 2021.**
- **Do not finalize proposals to score ACOs subject to MIPS under the APM Performance Pathway (APP). Instead we urge CMS to maintain the MIPS APM Scoring Standard.**

MSSP PROPOSALS

Changes to ACO Quality Scoring and Reporting

Proposals: CMS proposes major structural changes to the way MSSP ACOs are measured and assessed on quality. For 2021 and future performance years, CMS proposes to sunset the current approach of quality measurement for MSSP ACOs and replace it with a new APM Performance Pathway (APP) to better align with the Quality Payment Program (QPP). CMS also notes many ACOs are high performers under the current structure and the agency believes it is appropriate to require a higher standard of care in order for ACOs to continue to share in any savings they achieve. CMS also notes the agency believes holding ACOs to a higher standard is in line with CMS goals of incentivizing value-based care and driving the Medicare system to greater value and quality. Notably, the new APP would include fewer measures and a higher minimum attainment standard, which is the threshold that ACOs would be evaluated on to be eligible to share in savings earned.

Comments: While we appreciate CMS's goal of aligning methodologies across programs, we do not support CMS proposals to make such sweeping changes to how ACO quality is assessed, how quality data is reported, and how ACOs are evaluated on quality for both the Medicare Shared Savings Program (MSSP) and Merit-Based Incentive Payment System (MIPS). Further, these changes come amidst the unprecedented COVID-19 Public Health Emergency (PHE). The timing of these changes is very concerning as ACOs continue to deal with the uncertainty that the COVID-19 PHE is bringing to the health care industry. At a minimum we urge CMS to postpone making any structural changes to the way ACO quality is assessed or reported until at least 2022. Finally, while these proposed changes align more with the way individual clinicians and groups are scored in MIPS, it is a farther departure from the way CMS assesses other non fee-for-service providers, such as Medicare Advantage. Therefore, this effort at alignment is a step backward for ACOs and those committed to value.

Quality improvement is a cornerstone of the ACO model. In addition to reducing spending, ACOs must meet certain quality performance standards to be eligible to receive shared savings payments. ACOs continue to improve quality year over year, which improves patient care and helps to control costs. It is critical that CMS policies to evaluate ACO quality are fair, appropriate and accurately reflect the work ACOs undertake to improve patient care. CMS's proposals to change the way ACO quality is assessed, reported and scored for the purpose of shared savings calculation are significant and more feedback should be collected before moving forward with such drastic changes. Further, as stated in previous comments, NAACOS strongly believes ACOs should not be evaluated and assessed in the same manner as all other APMs or individual MIPS clinicians. ACOs are high-quality performers, however, this should not serve as a reason for CMS to overhaul the entire quality performance assessment approach for the MSSP. Instead, we urge CMS to work with NAACOS and other stakeholders to make changes to the current quality measure performance evaluation criteria and measure set for ACOs to further refine the measures and criteria as appropriate for a group of providers who are responsible for total cost of care for the populations they serve. Clinicians in MIPS who are not participating in total cost of care and full accountability payment models should not necessarily have the same quality measure set and scoring approach as ACOs. Likewise, each APM has specific goals and objectives, and the one size fits all approach under the proposed APP structure does not account for those differences.

The proposed APP attempts to apply one approach to a multitude of providers and APMs. The current MIPS APM Scoring Standard, in comparison, allows each APM to have its own set of unique quality measures and scoring approaches that best fit a particular model. This approach allows specific APMs to have meaningful quality measures tailored to their model's goals while still providing credit for quality improvement efforts to those who are also subject to MIPS. The proposed APP approach would instead

apply one set of quality measures for all APMs subject to MIPS. Therefore, each model participant would need to report not only their APM's specific quality measures, but also the APP quality measures (or other measures). This one size fits all approach results in more burden for APM participants and further may require the model participants to report on measures that are not applicable or appropriate. Finally, NAACOS has concerns that this policy, which may allow APMs to choose to select measures to report outside the APP instead of relying on the APM's own quality measures as is currently done, would allow certain organizations to select measures for which they have the highest historical performance, not allowing for a true and fair assessment of quality improvement efforts. We instead urge CMS to maintain the APM Scoring Standard approach.

Proposed APP Measure Set
Proposals: CMS proposes to dramatically decrease the number of measures ACOs are evaluated on for purposes of MSSP quality assessments. These measure scores would also be used to evaluate ACOs subject to MIPS for purposes of quality assessments. Table 36 on page 50233 of the proposed rule outlines the proposed new measure set for MSSP ACOs, which includes 10 Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures (counted as one measure under the APP), two administrative claims measures, and three clinical quality measures.

Comments: The proposed six APP measures are a drastic reduction from the 23 measures ACOs are currently assessed on. While NAACOS supports reducing reporting burdens and efforts to eliminate low value measures, we feel these proposals go too far by reducing the number of clinical quality measures to a mere three measures. Quality improvement is a critical and core component of an ACO's work. We therefore recommend CMS consider maintaining several key clinical quality measures that are foundational to an ACO's quality improvement work and have been proven to improve outcomes including: ACO-14, Influenza Immunization; ACO-19, Colorectal Cancer Screening; ACO-20, Breast Cancer Screening; and the previously used Pneumonia Vaccination measure. While ACOs can choose to continue to work on these preventive measures whether or not they are included in the MSSP's official measure list, we think it is critical for CMS to evaluate both individual ACOs and the program as a whole on these foundational prevention measures. Further, since the ACO program already gives ACOs a direct financial incentive to reduce avoidable admissions and readmissions, we do not feel it is appropriate to have one third of the total measure set focused on utilization measures. We also urge CMS to do more comparative research on how ACO quality on these core measures and improvement areas contrasts to non-ACO quality and to make the data and research findings public. This type of comparison cannot fairly be done if ACOs are only measured on one diabetes measure, one blood pressure measure, and one depression screening measure as proposed in the APP, nor does it reflect the true purpose and work ACOs do in the quality improvement space.

Additionally, we have concerns with the Screening for Depression and Follow-Up Plan measure, as well as the Days at Home measure discussed but not formally proposed. Understanding the degree to which individuals spend their time at home is a useful indicator to determine if the healthcare system is achieving one of its primary goals. While this indicator provides a viewpoint broader than measures such as admissions or readmissions, the many different factors that can affect patients' "healthy days at home" raise serious concerns about whether differences in performance on this measure can be reliably attributed to the services delivered by ACOs and whether it would truly distinguish the quality of care ACO participants deliver. We also are concerned with the controlling high blood pressure measure in its current state, which determines performance based on a single reading rather than taking into account the level of control over a period of time. There are also limitations in accepting patient reported home readings that can be more reflective of true control of high blood pressure than office-based readings. Further, the MIPS Unplanned Admissions for Multiple Chronic Conditions measure does not meet the

required 0.7 reliability threshold, and therefore we urge CMS to increase testing, particularly for risk adjustment, and increase case minimums for this measure before including it in the proposed APP measure set. Finally, the Unplanned Readmissions measure and CAHPS measures have very narrow bands, meaning very small differences in quality can result in very drastic quality score differences that are not meaningful and do not truly measure an ACO's quality improvement efforts. We recommend CMS work with stakeholders to make improvements to the specifications for these measures before using them as part of such a limited quality measure set as proposed in the APP.

Finally, while we support the inclusion of patient satisfaction measures, we have concerns that the number of CAHPS measures included in the APP is disproportionate to clinical quality and outcomes measures. There are several issues with the CAHPS measures as currently collected. As an example, the CAHPS measures use a very small sampling of patients and rely on patient recollection of experience that took place months prior. CMS should consider altering surveys to accept results from shorter surveys provided closer to real time and to a much larger population.

Removing the Web Interface Reporting Mechanism

Proposals: CMS proposes to eliminate the Web Interface as a reporting method for ACOs and all MIPS reporters beginning in 2021, citing low uptake of use outside the ACO program. In place of the Web Interface, the APP would require ACOs to actively report on three clinical quality measures, which could be reported using a registry or direct via electronic health records (EHRs) using electronic clinical quality measure (eCQM) standards. These eCQMs must be reported for all patients, regardless of payer.

Comments: CMS proposes to abruptly end the use of the Web Interface reporting mechanism, a tool that has been used since the MSSP's inception. Removing this option for all ACOs with little notice is ill-timed and unfair. Further, CMS has not been clear regarding how the alternative MIPS reporting options will be utilized for ACOs (as APM Entities) specifically. There are several key questions and obstacles to moving away from this reporting method in this timeframe. For example, the current remaining MIPS reporting options available under the APP would be registry (MIPS CQMs) and EHR (eCQMs). Using these reporting options would result in the ACO being evaluated on quality for all patients the ACO's providers serve, not only ACO assigned patients. This is not a true evaluation of the ACO's quality efforts and, additionally, raises contractual and legal concerns, as an ACO may not have the ability to access patient data for non-ACO patients. This would also make quality evaluations challenging. In effect, assessing ACOs on their quality actions for all patients rather than ACO patients would be evaluating the ACO's spillover effects and would not directly evaluate the true impact of their work on their ACO patients. Further, a goal of APMs is to promote provider investment in processes and tools to improve outcomes. Many ACOs have invested significant resources for development of reporting processes and workflows to optimize this process; removing this option altogether would undermine these investments, thus diverting critical resources away from improving patient care.

Additionally, making the switch to these alternative reporting options will cost many ACOs considerable time, money and effort in changing workflows, paying for registries and adapting and modifying EHRs to comply with eCQM standards. As an example, some ACOs would need to pay large fees for modifying EHRs to capture the appropriate quality data and to change performance dashboards. These fees can be significant, and a large hardship particularly for smaller ACOs. Other ACOs may need to explore working with registries, which again, could come with additional fees to the ACO. For these reasons, we urge CMS to provide a more gradual transition away from the use of the Web Interface reporting option to give more time and thought to how this will practically be implemented and to give ACOs more time to assess their alternatives. While NAACOS supports the movement toward more automated reporting, the timeline CMS proposes is unreasonable and creates a hardship for ACOs. Specifically, we urge CMS to

allow the Web Interface to be continued as an option for the foreseeable future while carefully considering additional reporting options for ACOs.

Finally, moving to a registry or EHR-based reporting method will significantly increase the number of patients an ACO must report on and be evaluated on under CMS proposals. Currently, ACOs must report on 248 ACO patients included in the Web Interface. Under the registry option, an ACO would have to report on 60 percent of their patients, both Medicare and non-Medicare patients as well as ACO and non-ACO patients. For the EHR reporting method, ACOs would be required to report on 70 percent of patients, both Medicare and non-Medicare as well as ACO and non-ACO patients. For some ACOs this could be a drastic increase and will therefore add significant administrative burden for the ACO. Should CMS finalize this approach, the agency should be requiring the ACO to report on, at a maximum, 50 percent of exclusively ACO patients. These specification issues and differences demonstrate why NAACOS feels an ACO-tailored approach to quality measurement and assessment is more appropriate than trying to make the MIPS program and standards apply to ACOs. This will be increasingly important as NAACOS predicts many ACOs will not be able to meet the increasing QP thresholds in the coming years and will therefore find themselves subject to MIPS, even those taking on the most advanced levels of risk.

Quality Benchmarks
Proposals: CMS proposes to use all MIPS reporters to establish benchmarks for ACOs under the new APP scoring approach. Further, due to anomalies in data due to COVID-19, CMS proposes to use PY 2021 information to establish 2021 quality benchmarks.

Comments: It is unfair to hold providers accountable for performance against a benchmark that would not be set until after the performance period has closed. Alternatively, we recommend CMS continue to monitor the data submitted by Web Interface reporters in 2019 and continue to evaluate the impact of COVID-19 on 2021 quality performance. As is the case for 2020, we suspect there will be a significant impact on quality improvement efforts in 2021 as a result of the COVID-19 pandemic, and we urge CMS to consider using alternative policies such as reverting all measures to pay-for-reporting or providing ACOs with historical performance scores.

Quality Scoring Methodology Changes
Proposals: CMS proposes to alter the scoring methodology currently used to assess MSSP ACO quality. As proposed, CMS would award a score of three-to-ten points for each measure in the APP that meets the data completeness and case minimum requirements, which would be determined by comparing measure performance to established benchmarks. Benchmarks would no longer be determined by looking at all Web Interface reporters, but rather, benchmarks would be established based on all MIPS reporters and would also vary based on the reporting method chosen by the ACO. Notably, CMS is proposing to remove the pay-for-reporting year currently provided to ACOs in their initial contract year or for new or substantively revised measures. CMS also proposes to change the minimum attainment standard to require ACOs to meet or exceed the 40th percentile among all MIPS reporters. Finally, as is currently the case, ACOs must also report on all measures in order to meet the minimum attainment standard.

In regard to how quality scores determine shared savings/loss rates, CMS proposes that ACOs must meet the minimum attainment standard to be eligible to share in any savings earned, however, once the minimum standard is met an ACO would receive the maximum shared savings rate automatically regardless of the ACO's final quality score. If an ACO does not meet the minimum attainment standard, the ACO would not be eligible for shared savings. To determine shared loss rates, CMS proposes to use an approach that would award ACOs with higher quality scores a lower shared loss rate (and vice versa), except for risk-based Basic Track ACOs that will continue to apply a fixed 30 percent shared loss rate.

Finally, CMS notes ACOs that fail to meet the minimum attainment standard and are responsible for shared losses would owe the maximum shared loss rate.

Comments: NAACOS opposes the proposal to remove the pay-for-reporting year currently provided to ACOs beginning an initial MSSP contract, as well as individual measures that are newly introduced to the measure set. This change would also remove the ability of CMS to provide a pay-for-reporting year when measures undergo significant changes, such as guideline and specification changes. Providing the pay-for-reporting year is critical to an ACO's success. This flexibility in scoring when a measure undergoes significant changes allows an ACO to evaluate their current workflows, data capture processes and other operational strategies to see where changes are needed and what areas to focus on. Further, providing a newly introduced measure with a pay-for-reporting year ensures there are no unintended consequences or flaws in the measure specifications before holding an ACO accountable for performance on the measure. Allowing this time to assess workflows and operations before ACOs are held accountable for performance on measures allows ACOs to be successful in getting credit for the good quality improvement work they are already engaged in, as often times a measure is not only assessing true quality but also how the quality data are captured. We urge CMS to not finalize this approach and instead maintain the pay-for-reporting year provided to ACOs in their initial contract year, as well as new quality measures when they are introduced or significantly changed. The current MIPS policy would allow for suppression of a measure that undergoes significant specification changes: under the proposed new APP scoring approach this would significantly disadvantage ACOs who could see drastic swings in their performance based on suppression of just one measure.

Additionally, NAACOS opposes the overall approach proposed for ACO quality scoring. With upcoming changes to MIPS through the MIPS Value Pathways and exemptions due to extreme and uncontrollable circumstances such as for COVID-19, the 40th percentile of the Quality Category score could vary greatly from year to year making it a less meaningful indicator of true performance. Instead, should CMS move forward with proposals to re-design the quality assessment structure for ACOs, we urge CMS to utilize a scoring approach that is more similar to the current domain-based scoring approach instead of using an all-or-nothing approach as proposed. As an example, CMS could instead consider a policy that would use a minimum attainment standard that requires 50 percent of the quality measures to meet or exceed the 40th percentile. This must be done in conjunction with our recommendations to add additional clinical quality measures to the measure set beyond the three that CMS has currently proposed. Setting the standard at 50 percent ensures that ACOs perform well on a substantial set of measures to earn savings but does not punish ACOs that miss the mark on a measure that is either not as relevant to their patient population or has a very narrow range of performance rates. Finally, NAACOS also urges CMS to better reward high quality performers, as is done in the Medicare Advantage program by providing bonuses or higher shared savings rates to high quality performers or those that notably improve quality scores over time.

Alternative Proposal Allowing ACO Selection of Quality Measures

Proposals: CMS seeks comment on an alternative approach that ACOs could use in the event "the three measures ACOs are required to actively report on are not applicable to their beneficiary population." In this case, the ACO could choose to opt out of the APP and report to MIPS as an APM Entity selecting more appropriate measures available under MIPS. CMS does not include any further details regarding how CMS would determine if the three required measures were not applicable to the ACO.

Comments: NAACOS opposes this approach to provide ACOs the option of selecting alternative quality measures to report. First, we cannot contemplate instances when the proposed APP measures listed would be determined to not apply to an ACO. Second, allowing this option would make program evaluation nearly impossible. Evaluating ACO's impact on quality should be a key focus for CMS and,

therefore, there should be one standard set of quality measures that apply to all ACOs participating in the model. Finally, NAACOS has concerns that this policy would allow certain organizations to select measures for which they have the highest historical performance, not allowing for a true and fair assessment of quality improvement efforts across ACOs.

Awarding the Higher of the 2019 or 2020 ACO Quality Score and CAHPS Changes for 2020 Due to COVID-19 PHE

Proposals: CMS seeks comment on an option that would provide ACOs the higher of their 2019 or 2020 quality scores for PY 2020 due to the impact of the COVID-19 PHE, so long as ACOs fully report on quality measures in 2020. Additionally, due to the negative impact of COVID-19 on sample size and performance scores, CMS proposes to remove the requirement for ACOs to field a CAHPS for ACOs survey for PY 2020. Instead, CMS proposes to provide automatic full points for each of the CAHPS survey measures within the patient/caregiver experience domain for PY 2020.

Comments: NAACOS is pleased to see CMS providing a fallback option for 2020 quality scores due to the impact of COVID-19. While NAACOS prefers to see all measures reverted to pay-for-reporting in 2020, we support this alternative approach that will protect ACOs whose quality scores are affected by the COVID-19 pandemic. We are also pleased to see CMS remove the requirement for ACOs to field a CAHPS for ACOs survey in 2020 and provide full points automatically for each of the CAHPS survey measures. We urge CMS to finalize these proposals. We also ask CMS to begin considering alternative polices and exceptions for the COVID-19 PHE for PY 2021, which CMS does not address or discuss in this proposed rule. The COVID-19 pandemic will continue beyond January 1, 2021, and while the severity and impact of the pandemic in 2021 are unknown at this time, we urge CMS to also provide the fallback option of making all quality measures pay-for-reporting in 2021, or alternatively providing ACOs with historical performance scores. ACOs need certainty that they will be protected from the affects of the pandemic on quality, which are outside their control.

Quality Measure Specification Changes

Proposals: CMS proposes several notable measure specification changes for the ACO Web Interface quality measures for 2021. CMS proposes to add denominator exclusions for advanced illness and frailty for the breast cancer screening and colorectal cancer screening measures. CMS also proposes to update specifications for certain Web Interface measures to allow telehealth encounters as eligible encounters.

Comments: As noted above, we urge CMS to keep in place the current measure set, reporting mechanism and scoring methods for ACO quality in 2021. Therefore, we support CMS proposals to add denominator exclusions for advanced illness and frailty for the breast cancer and colorectal cancer screening measures, as previously advocated for by NAACOS. These important exclusions will ensure unnecessary care is not provided to patients with advanced illness. Additionally, NAACOS supports updates to specifications to add telehealth encounters as eligible encounters, however, we note that certain measures do not list these changes as applicable when reporting via the Web Interface. CMS should clarify that all specification updates will apply regardless of reporting method and including measures reported via Web Interface. CMS should also clarify the proposed changes to the influenza immunization measure. CMS notes a qualifying encounter must occur between January 1 and March 31, 2021 for the 2020 timeframe. For the 2021 timeframe CMS notes the qualifying encounter must occur between October 1, 2021 to December 31, 2021. This is a significant change, or an error. Instead we urge CMS to clarify the 2021-2022 qualifying timeframe is at a minimum between September 1, 2021 and December 31, 2021 in order to capture those that receive their flu shot in September, and we urge CMS to capture the entire flu season as has been the case in the past, looking at September 2021 through March 2022. Additionally, needing an in-person encounter for the flu shot during a predefined timeframe is not

practical, whether it is a telehealth encounter or in-person encounter. Many patients will receive the flu shot at a pharmacy, where there is a Part B charge but not an encounter. These patients receiving flu shots in the pharmacy setting should meet the measure criteria as well.

Adjustments to the MSSP Extreme and Uncontrollable Circumstances Policy
Proposals: CMS proposes to make changes to the quality portion of the MSSP Extreme and Uncontrollable Circumstances policy for ACOs to align with the proposed changes to introduce a new APP for ACOs. For PY 2021 and subsequent years, CMS proposes to provide an ACO affected by an extreme and uncontrollable circumstance with the higher of its own quality score or a score equal to the 40th percentile MIPS Quality Performance Category Score. CMS also proposes to use the quarter four list of assigned beneficiaries to determine the portion of patients affected by the extreme and uncontrollable circumstance.

In addition, CMS seeks comment on a potential alternative Extreme and Uncontrollable Circumstances Policy for PY 2022 and subsequent years. Specifically, CMS proposes to adjust the amount of shared savings determined for affected ACOs that complete quality reporting but do not meet the quality performance standard, or that are unable to complete quality reporting. Under this alternative approach, CMS would determine shared savings for an affected ACO by multiplying the maximum possible shared savings the ACO would be eligible to receive based on its financial performance and track (or payment model within a track) by the percentage of the total months in the performance year affected by an extreme and uncontrollable circumstance and the percentage of the ACO's assigned beneficiaries who reside in an area affected by an extreme and uncontrollable circumstance.

Comments: We do not support CMS making further changes to the MSSP Extreme and Uncontrollable Circumstances policy at this time. Given the vast changes proposed to the MSSP Extreme and Uncontrollable Circumstances policy over the last two years and the additional, alternative policies that have been put in place in 2019 and 2020 to account for COVID-19, CMS should refrain from making any significant changes to this policy at this time and continue to assess the COVID-19 pandemic in 2021 before making any further changes to the established policy. As noted above, we also urge CMS to begin considering alternative policies for 2021 due to COVID-19 for both financial and quality assessments for ACOs. As noted above, we do not support CMS proposals to change ACO quality assessments, and therefore we also do not support the proposed changes to the MSSP Extreme and Uncontrollable Circumstances Policy to align with the new APP proposals.

Repayment Mechanism Requirements
Proposals: CMS proposes to eliminate the requirement that a renewing ACO maintain a higher repayment mechanism amount than would otherwise be required under the new agreement period if the ACO's repayment mechanism amount for the final year of its previous agreement period was greater than the repayment mechanism amount calculated for the new agreement period. CMS also proposes to allow ACOs an option to decrease their repayment mechanism amounts if the recalculated amount is less than the current amount. If finalized, this policy would be in place beginning with Performance Year (PY) 2022. The agency also proposes to allow eligible ACOs that renewed their agreements effective July 1, 2019, or January 1, 2020, an opportunity for a repayment mechanism decrease.

Comments: Securing a repayment mechanism is a regulatory burden, which is time consuming and costly for ACOs. We appreciate CMS's efforts to minimize burdens associated with the repayment mechanism. Currently, a renewing ACO that wants to use its existing repayment mechanism in the subsequent agreement period is required to maintain a higher repayment mechanism amount than necessary for its new agreement period if the repayment mechanism amount for the last performance year of the

previous agreement period is greater than what is needed for the subsequent agreement period. We support CMS's proposal to eliminate this requirement and recommend it be finalized.

Under the Pathways to Success regulations when a recalculated repayment mechanism increases by a certain amount (i.e., the lesser of 50 percent or $1,000,000), CMS requires the ACO to increase the value of the repayment mechanism. However, CMS does not currently decrease the repayment mechanism amount when the opposite occurs, a policy for which NAACOS has advocated and which the agency proposes to change in this rule. We appreciate CMS's proposal to allow ACOs an option to decrease their repayment mechanism amount if the recalculated amount is less than the current amount, and we request the agency finalize this policy. We also support CMS providing an opportunity for ACOs that renewed their agreements effective in 2019 or 2020 an opportunity to benefit from this policy change, if finalized, by adjusting their repayment mechanism amounts already in place, if they quality under the revised policy.

We support CMS's proposals in the rule, but we also urge the agency to take additional steps to minimize burdens associated with repayment mechanism requirements. Many ACOs cite the burden and cost of securing a repayment mechanism as reasons not to move to a risk-based ACO model. Instead of requiring a repayment mechanism that pays banks and brokers and takes money away from the ACO executing its core mission of improving patient care, we urge CMS to remove the repayment mechanism requirement when an ACO can prove that it has an investor or financial backer with a demonstrated high credit rating. Financial backers could include outside investors, insurers or hospitals or health systems that are involved with the ACO and providing financial support, which would be available should losses occur. This assurance would protect the Medicare Trust Fund in the event the ACO has losses while avoiding the financial inefficiency and regulatory burden of involving outside financial institutions as third parties that benefit from the repayment mechanism requirements. This would also eliminate the need to have a 24-month tail period. The additional burden of a 24-month "tail period" heightens concerns and increases financial requirements for ACOs. Should CMS maintain requirements for a repayment mechanism, we request the agency to minimize this regulatory and financial burden by removing the requirement for tail period coverage, which is especially important considering the longer agreement periods

Track 1+ Proposals

Proposals: CMS clarifies that to align Track 1+ policies with MSSP policies, the agency is providing Track 1+ ACOs whose agreement periods are set to expire December 31, 2020, an opportunity to voluntarily extend their agreement period for a fourth performance year in 2021. Additionally, CMS clarifies that the proposed MSSP policies in this rule would apply to Track 1+ ACOs in the same way they apply to Track 1 ACOs as long as the applicable regulation has not been waived under the Track 1+ Model.

Comments: We thank CMS for taking action to provide more flexibility to ACOs during the COVID-19 pandemic. We strongly support the option provided to ACOs with agreements ending December 31, 2020, to extend their agreements for an additional performance year and appreciate the agency clarifying that this policy also applies to Track 1+ ACOs. This will provide much needed stability for ACOs in an uncertain time.

MSSP Beneficiary Assignment

Proposals: CMS proposes to amend the list of primary care services the agency uses to assign beneficiaries to ACOs by adding nine more codes and making technical changes to existing codes used in assignment starting in PY 2021. CMS also proposes to exclude advance care planning services when billed in an inpatient setting from being used to determine beneficiary assignment starting in PY 2021 and to exclude professional services furnished by Federally Qualified Health Centers (FQHCs) or Rural Health

Centers (RHCs) when those services are delivered in a skilled nursing facility (SNF).

Comments: NAACOS supports updating the definition of primary care codes used for MSSP assignment. Assignment is a critical program methodology that determines the beneficiary population for which an ACO is held accountable. Adding codes such as "e-visits," chronic care management, and principal care management will help create a better picture of where patients receive most of their primary care. CMS should continue to refine the primary care codes used in assignment, and we request that the agency do so in a timely manner. We recommend CMS finalize adding the nine proposed codes to the MSSP assignment methodology.

NAACOS also appreciates CMS's desire to ensure that patients are attributed to providers from whom they receive their primary care services. Therefore, we support excluding advance care planning services from MSSP assignment when billed in an inpatient setting and also excluding professional services furnished by FQHCs or RHCs when delivered in a SNF. Both of these changes, while technical in nature, help create more complete and accurate patient assignment lists for ACOs and we recommend the agency finalize these proposals.

While NAACOS appreciates CMS's work to refine assignment during the COVID-19 PHE, NAACOS recommends that CMS use a two-year assignment window for MSSP to account for potential variations in attribution in 2020 and 2021. Especially in states hit harder by the pandemic, healthy patients may forego routine primary care and throw off assignment for MSSP ACOs who use either retrospective or prospective attribution. Therefore, patient visits from 2019 and 2020 should be considered for ACOs' assignment lists regardless if ACOs choose prospective attribution or retrospective attribution. While the windows for either groups of ACOs will be different, the same general principle applies and would help create more steady and accurate assignment lists. The Next Generation ACO Model uses a two-year assignment window already.

PHYSICIAN FEE SCHEDULE PROPOSALS

Evaluation and Management Services (E/M)

Proposals: The proposed 2021 MPFS Rule continues the approach finalized by the agency in last year's MPFS rule, which updates office and outpatient E/M services based on a framework from an American Medical Association Current Procedural Terminology (AMA CPT) Workgroup on E/M. Many of the previously finalized policies on E/M, including new revised payments and new codes and reporting requirements, go into effect in 2021, resulting in budget-neutral payment shifts within the physician fee schedule.

To maintain relativity with the increased office/outpatient E/M values, CMS proposes to revalue certain services and code sets that include, rely upon, or are analogous to office/outpatient E/M visits. Among the codes and codes sets with values closely tied to the those for office/outpatient E/M visit codes are: TCM services (CPT codes 99495, 99496); cognitive impairment assessment and care planning (CPT code 99483); certain end-stage renal disease (ESRD) services (CPT codes 90951 through 90970); and the annual wellness visit (AWV) and initial preventive physical exam (IPPE) (HCPCS codes G0402, G0438, G0439), among others. Many of these services were valued via a building block methodology and have office/outpatient E/M visits explicitly built into their definition or valuation. CMS proposes to update the valuation of these codes, including Relative Value Units (RVU) and input changes.

CMS also proposes to adjust a code that the agency finalized last year and will go into effect in 2021. This add-on code, 99XXX, is for prolonged office or other outpatient E/M services, requiring total time beyond the usual service, and reflects additional resources used for E/M codes 99205 and 99215. CMS proposes that when the time of the reporting physician or non-physician practitioner (NPP) is used to select office/outpatient E/M visit level, CPT code 99XXX could be reported when the maximum time for the level five office/outpatient E/M visit is exceeded by at least 15 minutes on the date of service.

Comments: CMS has long acknowledged the need to revise payment, guidelines, and documentation requirements for billing E/M services and has taken notable steps in recent years to do so. In the final 2020 MPFS Rule the agency finalized significant changes to outpatient and office E/M services, including implementing a revised approach to updating E/M services based on a framework from an AMA CPT Workgroup on E/M. NAACOS strongly supports CMS's work to modernize E/M codes and payment to support the delivery of higher quality, lower cost patient care. The new coding framework will reduce administrative burdens and better describe office visits as they are performed today. We support the proposal to maintain relativity with the increased office/outpatient E/M values by revaluing certain services and code sets that include, rely upon, or are analogous to office/outpatient E/M visits. However, given the payment disruptions to certain providers, we recommend that CMS work with the medical community to urge Congress to implement positive updates to the Medicare conversion factor to offset the deserved increases to office visits.

We support CMS's proposal to adjust add-on code, 99XXX, for prolonged office or other outpatient E/M services, requiring total time beyond the usual service, and reflects additional resources used for E/M codes 99205 and 99215. We request CMS finalize its proposal that when the time of the reporting physician or non-physician practitioner (NPP) is used to select office/outpatient E/M visit level, CPT code 99XXX could be reported when the maximum time for the level five office/outpatient E/M visit is exceeded by at least 15 minutes on the date of service. We appreciate CMS's effort to describe and reward the work associated with visits that are part of ongoing, comprehensive primary care through use of add-on codes such as 99XXX. It is important to have add-on codes to reflect additional resources used for E/M codes.

Telehealth
Proposals: CMS proposes to permanently add nine codes to the list of those eligible to be delivered via telehealth, while temporarily adding another 13 codes through the calendar year for which the COVID-19 PHE ends so that more evidence can be collected on their use. CMS also seeks comments on other codes that could be delivered via telehealth in certain circumstances, for example in some models of care delivery that use a combination of remote monitoring and clinical staff at the location of the beneficiary.

CMS seeks comment on Medicare allowing initial SNF visits from physicians and other clinicians to be via telehealth. The agency also seeks comments on additional non-face-to-face services that could be delivered through technology but that Medicare doesn't currently cover. Additionally, CMS wants to know any impediments or barriers providers face to bill for telehealth, remote patient monitoring, or other communications technology-based services.

Comments: NAACOS appreciates CMS's responsiveness during the COVID-19 PHE to help offer frontline providers the tools they need to care for patients during the pandemic. This includes numerous policies and waivers around telehealth, which has been very helpful to ACOs. Telehealth's use exploded within ACOs once the pandemic hit. According to a NAACOS survey, more than half of ACOs replaced between 10 percent and 24 percent of lost in-person visits with telehealth at one point in early May. About 10 percent of ACOs replaced at least half of lost in-person visits with telehealth. NAACOS continues to urge

CMS to expand telehealth in ways that are thoughtful, clinically meaningful, and that ultimately improve patient care.

NAACOS also believes alternative payment models, including ACOs and other value-based payment models, offer the best avenue for Medicare to expand telehealth coverage. Providers in these models are conscientious of patients' long-term care and spending, and, therefore, will use telehealth in ways that will benefit patients' needs — while protecting Medicare from fraud, abuse and overuse. We hope a close examination of telehealth's use throughout the COVID-19 PHE will reveal that utilization within ACOs replaces certain in-person visits in a way that complements a comprehensive care plan emphasizing the right care in the right setting.

To date, however, CMS has limited telehealth waivers in ACOs, including MSSP and related CMS Innovation Center models, to patients' geographic location and originating site, allowing telehealth to be delivered to patients outside of rural settings and in their homes. Instead, NAACOS urges that CMS use its statutory authority under 42 U.S.C. 1315a(d)(1) (in the case of CMMI models) and 42 U.S.C. 1395jjj(f) (in the case of MSSP) to allow all ACOs, regardless of risk level or choice of attribution, the freedom to use telehealth in broader circumstances. This includes expanding waivers beyond the patient's site of care and geographic location.

Specifically, CMS should provide ACOs access to a broader set of telehealth waivers and expand what telehealth waivers cover, for example, waiving patient cost-sharing, additional modalities like telephone-only, supervision allowances, waivers on the frequency of telehealth visits, and covered services, such as those CMS says need some level of in-person care delivered in conjunction with telehealth. ACOs should be allowed greater freedoms to see patients — attributed through either prospective assignment or preliminary prospective assignment — without requirements on needing a corresponding in-person visit within a specified period of time after the telehealth visit. In the remote monitoring space, CMS could allow ACOs to monitor patient health for shorter periods of time and wider sets of clinical circumstances, as the agency seeks comment on elsewhere in the proposed rule. Because ACOs take accountability for a patient population, CMS should grant them the tools to care for those populations in ways that they see best, and waivers shouldn't be limited to patients' geographic location and originating site. Enacting these changes would achieve a dual purpose of expanding the reach of telehealth — with the access to care and quality improvement it brings — along with enticing more providers to join value-based payment models like ACOs.

Adding services to the Medicare telehealth list

NAACOS generally supports CMS's proposed expansion of codes covered on the Medicare telehealth list, and we encourage the agency to look at adding additional codes in the future. This includes switching codes temporarily covered on the new "Category 3" list to the list of codes permanently covered. Creation of this third category of codes provides an opportunity to expand Medicare's list of telehealth-eligible services, which we hope CMS takes advantage of in next year's MPFS rulemaking, if not sooner.

However, we recommend CMS reconsider its thinking regarding services that the agency says might require some level of in-person care to be safely delivered via telehealth. NAACOS opposes tethering certain telehealth services to some sort of in-person visit. We believe clinicians can deliver high-quality exams through modern technology. For example, one ACO member has most of its hospitalists working remotely. While there are instances where an in-person exam might be needed, CMS should avoid arbitrary limits, such as a length of time between a telehealth and in-person visit, for certain subsets of codes. Instead, CMS should allow a patient's provider to determine what is clinically appropriate.

This is an example where CMS could broaden its current waiver authority for ACOs to allow attributed patients the freedom to receive telehealth care without an in-person exam. If ACOs are willing to take financial responsibility for patients, they should be allowed by CMS to provide care in a way that best serves their patients.

Payment for audio-only visits
NAACOS appreciates CMS's work to provide broader coverage of audio-only services during the COVID-19 PHE. ACOs were clear that they could not adequately reach all of their patients through video-based telehealth, so audio-only services were critical. Their use will still be critical once the PHE is lifted as many seniors will continue without access to video-based visits, either because they lack access to technology, broadband to conduct video-based visits, or the technological literacy. For these patients, the choice is not between a video visit and a phone visit — it is the choice between an audio visit and no visit. We risk widening health disparities without greater access to audio-only telehealth.

While CMS should create new, audio-only telehealth codes, NAACOS believes those new services should be paid less than video-based visits. Audio-only visits, while needed for certain patients and in certain circumstances, aren't typically as clinically meaningful as video visits. Therefore, CMS shouldn't incentivize their use by creating parity in payment between audio-only care and video-care. The new codes CMS is looking to create should, however, be paid at a higher rate than then current virtual check-ins if there's more time needed for each service and they require more work by clinicians.

CMS should also learn from previous work of virtual check-ins to reduce regulatory burden that may limit their utility. NAACOS believes that uptake of virtual check-ins has been slow because of regulatory barriers. For example, CMS set limits around when the service can be delivered (to established patients not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours), to whom (established patient), and consent. CMS should to the furthest extent possible remove regulatory barriers to increase uptake of these services.

Risk adjusting for audio-only telehealth
NAACOS urges CMS to count diagnoses obtained from audio-only telehealth services for risk adjustment purposes. As stated above, many patients lack access to video-based visits. As more services are delivered through audio-only technology and as the PHE continues, it will be important for CMS to count diagnoses obtained from audio-only telehealth services for risk adjustment purposes. Not including these services in risk scores may inaccurately reflect the sickness of patient populations, which both undermines Medicare's move to value and leaves sick patients potentially vulnerable.

Furnishing telehealth visits in skilled nursing settings
NAACOS supports CMS allowing initial SNF visits from physicians and other clinicians to be via telehealth. Our ACO members have found this valuable during the COVID-19 PHE and would like to see this waiver continue once the emergency ends. CMS should also finalize a proposal to allow subsequent nursing facility visits to be conducted via telehealth once every three days, rather than the current 30-day limit. As stated above, high-quality care can be delivered through telehealth, and CMS should seek to remove arbitrary limits on telehealth care, such as how often care can be delivered through the technology.

Remote Physiologic Monitoring (RPM) Services
Proposals: CMS makes several clarifications on RPM coverage in the proposed rule, including that it will allow patient consent to be obtained at the time services are delivered, RPM may be billed to patients with acute conditions, as well as chronic conditions, and restricting RPM services to established patients

once the COVID-19 PHE ends. The agency clarified that for RPM services medical devices should digitally upload patient so that it is not self-recorded or self-reported.

CMS sought comment on whether the current suite of RPM billing codes accurately and adequately describes the full range of clinical scenarios that may benefit patients. For example, patients may benefit from fewer than 16 days of remote monitoring, and the agency is considering new billing codes and payment rules that would allow clinicians to bill and be paid for RPM with shorter monitoring periods.

Comments: RPM is an important and growing technology that will improve the efficiency of the delivery of health care services. RPM is an area that ACOs have adopted during the pandemic, so NAACOS appreciates CMS's work to increase its use by reducing regulatory burden while preserving patient safety.

NAACOS is concerned, however, that making RPM services too easy to bill might make it susceptible to fraud, abuse and overuse. However, CMS must strike a good balance between making remote monitoring accessible and creating regulatory barriers to prevent fraud and abuse. For example, CMS's proposal to require remote monitoring devices to automatically upload data is appreciated because of fraud, abuse and overuse concerns that come with patient-reported or patient-recorded data. Requiring patients to submit their own data isn't always reliable. CMS allowing RPM for acute conditions yet limiting it to established patients is an example of striking a good balance to combat fraud and abuse yet expanding its possible use.

NAACOS supports more RPM codes to cover monitoring periods less than 16 days, but requests that CMS be careful that monitoring is clinically meaningful. For example, patients self-reporting pain for post-surgery recovery is not a good use of RPM services. CMS could consider, for example, an at-home modifier for established codes, rather than an entirely new code, because some at-home monitoring may not lend itself to clinically meaningful care.

QPP PROPOSALS

Advanced APM Proposals

QP Thresholds

Proposals: In PY 2021, which corresponds to Payment Year 2023, the QP payment amount threshold increases from 50 percent to 75 percent, and the QP patient count threshold increases from 35 percent to 50 percent. Despite a growing number of Advanced APMs, in the rule CMS predicts that the number of QPs will go down slightly in PY 2021 as compared to 2019 and 2020. Specifically, the agency estimates that there will be between 196,000 and 252,000 QPs for PY 2021 with total bonuses of between $700 million and $900 million.

Comments: NAACOS appreciates the opportunities presented by CMS for providers to move to Advanced APMs, including extending current models such as the Next Generation Model and introducing new opportunities including the Direct Contracting Model. However, the numbers of QPs predicted in the proposed rule illustrates stagnant growth and a stalled transition to value. NAACOS urges that CMS provide additional opportunities for providers to become QPs, such as allowing new ACOs to join the MSSP in 2021 and moving forward with implementation of new models.

We also request CMS provide the maximum flexibility with the patient count QP thresholds and maintain the patient count threshold at 35 percent for PY 2021. In a recent NAACOS survey, more than 90 percent

of ACO respondents reported they are concerned they will not meet the QP thresholds in 2021, with 43 percent stating that they are "extremely concerned." Almost 80 percent of survey respondents indicated it will be difficult or very difficult to meet the 2021 thresholds. NAACOS has repeatedly advocated to modify QP calculations, and we have worked with our congressional champions to introduce the Value in Health Care Act, summarized here, which would prevent the QP thresholds from rising in 2021. We request that CMS work with Congress to ensure successful MACRA implementation by setting reasonable QP thresholds.

Advanced APM Incentive Payment

Proposals: CMS proposes to clarify that the Advanced APM incentive amount is calculated based on the paid amount, not the allowed amount, of the applicable claims for covered professional services that are aggregated to calculate the estimated payments.

Comments: NAACOS is very disappointed with the clarification to base the Advanced APM bonus on the aggregate paid amounts as opposed to the aggregate allowed amounts. There have been a number of references in CMS regulations and materials, such as the one below, to the agency basing the Advanced APM bonus on the aggregate allowed amounts, not the aggregate paid amounts which are roughly 20 percent lower.

> **"**We believe it is appropriate to maintain consistency across the QP determination and the incentive payment calculation in order to support internal CMS operational consistencies. It also ensures that any unique payment mechanisms within an Advanced APM do not affect the opportunity for an eligible clinician to reach the QP threshold. We solicited comment on whether the claims methodology we use under the Medicare payment method should align with the proposed claims methodology for purposes of calculating the estimated aggregate payment amount for the APM Incentive Payment.[…]
>
> Response: We do not believe it would be appropriate to use the Medicare paid amount instead of the allowed amount when calculating Threshold Scores. The Medicare paid amount reflects any reductions from the Medicare PFS amount for beneficiary co-payments or coinsurance requirements, and also reflects any payment adjustments that are applied to fee schedule payments, such as positive or negative payment adjustments from the PQRS, MU, VM, or MIPS programs. Including these adjustments is inconsistent with our proposal to exclude payment adjustments from these programs that we finalized in section II.F.8. of this final rule with comment period. We are finalizing that for the QP payment amount method we will use all available claims information for Medicare Part B covered professional services during the applicable QP determination period as described in this section of the final rule with comment period." Source: 81 Fed. Reg. 77008, 77453 (Nov. 4, 2016).

Following the release of the initial Advanced APM bonuses in late 2019, providers expressed surprise and disappointment over the bonuses being lower than expected. Those expectations were based on CMS language and the agency should honor its word. Therefore, NAACOS urges CMS to base the bonus on the aggregate allowed amounts and to retroactively pay providers the difference between the allowed and paid amounts.

Proposals: CMS acknowledges the complexity of distributing Advanced APM bonuses when clinicians are no longer practicing at Tax Identification Numbers (TINs) associated with earning their Advanced APM bonus. Therefore, the agency proposes an eight-step hierarchy for identifying where to pay the Advanced APM bonus, starting with a TIN tied to where the QP earned the Advanced APM status and ending with a

proposal to publicly list QPs for whom the agency could not identify a TIN to which to make the payment and requiring those QPs to contact CMS and provide Medicare payment information.

Comments: NAACOS appreciates the agency's attempts to locate and pay clinicians who earned the Advanced APM bonus. However, we urge the agency to instead pay these bonuses directly to the APM Entity, such as an ACO, as is done with the shared savings payments for ACO participation. It adds considerable complexity for CMS to track these individuals, and they are only eligible for these bonuses based on their participation in the qualifying APM Entity. Paying the APM Entity directly reinforces its role and further incentivizes the shift to value.

QPs and Partial QP Determinations

Proposals: CMS acknowledges that when a beneficiary is prospectively assigned to an ACO or other APM Entity, and therefore could not possibly be assigned to other ACOs or APM Entities, it is unfair to include that beneficiary in those QP calculations. Therefore, CMS proposes to exclude prospectively assigned beneficiaries from the denominators of other ACO/APM Entity QP calculations when that beneficiary is ineligible to be added to the ACO/APM Entity's list of assigned beneficiaries.

Comments: Currently, for QP calculations, a beneficiary may be counted only once in the numerator and denominator for a particular ACO or APM Entity but that a beneficiary may be counted multiple times across the numerators and denominators for different ACOs (or other APM Entities). CMS's proposal to remove beneficiaries from denominators of APM Entities for which they are ineligible to be included in the numerator is logical and fair, especially in the face of rising QP thresholds. NAACOS strongly supports this proposal and requests the agency finalize it along with a clarification that this would pertain to APM Entities regardless of assignment methodology. On page 50334 of the proposed rule, CMS states:

> "Therefore, we propose to amend § 414.1435(c)(1) of our regulations and add a new paragraph § 414.1435(c)(1)(i) to specify that beneficiaries who have been prospectively attributed to an APM Entity for a QP Performance Period will be excluded from the attribution-eligible beneficiary count for any other APM Entity that is participating in an APM where that beneficiary would be ineligible to be added to the APM Entity's attributed beneficiary list. The effect of this proposed policy would be to remove such prospectively attributed beneficiaries from the denominators when calculating Threshold Scores for APM Entities or individual eligible clinicians in Advanced APMs that align beneficiaries retrospectively, thereby preventing dilution of the Threshold Score for the APM Entity or individual eligible clinician in an Advanced APM that uses retrospective attribution."(emphasis added)

This language in the preamble caused concern among ACOs that the proposal would only remove beneficiaries from the denominators of ACOs or APM Entities using retrospective assignment. While the proposed regulatory language at §414.1435 does not appear to limit this policy to APM entities with retrospective assignment, we request CMS finalize a policy that it would apply regardless of attribution methodology and to provide clear examples in the preamble to that effect.

Partial QP Election

Proposals: CMS requests comment on whether to allow an APM Entity, such as an ACO, to make the Partial QP election on behalf of all the individual eligible clinicians associated with the APM Entity. The election would apply to whether the Partial QPs want to participate in MIPS and have MIPS payment adjustments since Partial QPs are ineligible to earn Advanced APM bonuses as a result of falling short of QP thresholds.

Comments: NAACOS supports this proposal that would help ease administrative burdens associated with making a Partial QP election. This will be especially helpful as QP thresholds rise to unrealistic levels and more clinicians are unable qualify. Many of whom will be deemed "Partial QPs." We recommend CMS finalize this as proposed.

Targeted Review

Proposals: CMS proposes to establish a targeted review process for limited circumstances surrounding QP determinations, such as to review CMS clerical errors like omitting a clinician from a participation list used for QP determinations. After a specified time period for a targeted review, there would be no further review of QP determinations with respect to an eligible clinician for the QP Performance Period, and there continues to be no administrative or judicial review for QP determinations. If CMS determines a clinician was missing due to CMS clerical error, the agency proposes to assign the ACO or APM Entity's most favorable QP score from that performance year. A review could be submitted by an eligible clinician or APM Entity during a specified 60-day review period announced by CMS.

Comments: NAACOS applauds CMS's proposal to allow review of QP calculations, but we urge the agency to expand this opportunity beyond a targeted review of clerical CMS errors. ACOs spend millions of dollars in start-up costs and ongoing operational expenses to fund key initiatives and assume risk. The Advanced APM incentive is very important to fund these activities. In fact, in a recent NAACOS survey on the Advanced APM incentive and QP thresholds, 100 percent of ACOs respondents said the Advanced APM incentive is important to their ACO, with 84 percent reporting it is "extremely important." It is imperative that as CMS implements MACRA the agency provides more transparency on how QP calculations are completed as well as enough information for ACOs to recreate their QP scores to verify their validity. Unfortunately, ACOs continue to report inaccuracies with the information displayed on the QPP portal (lookup tool). Providing a meaningful opportunity for reviewing QP calculations and determinations is essential to building provider confidence in how CMS is managing the important transition to value.

ACOs rely on CMS and its contractors to execute complex program methodologies and operations, such as determining QP scores. These methodologies and calculations are essential to the QPP and determine whether an APM Entity receives an Advanced APM bonus. However, these methodologies and their corresponding calculations are not fully disclosed. While CMS shares its general approaches, and ACOs do their best to replicate CMS's work, the agency does not provide the level of detail needed for ACOs to make their own precise calculations. CMS should be fully transparent with its methodologies and calculations, and ACOs should be able to replicate them on their own. We urge CMS to share the exact algorithms for these important methodologies and calculations. This will help ensure transparency and accountability of CMS. It is essential that CMS provide increased transparency of QPP calculations, including the details ACOs need to replicate formulas and make their own calculations.

Finally, the proposal notes that targeted reviews will be limited and would occur within a 60-day window. We urge the agency to expand the window to no shorter than 120 days to allow ACOs to review details and conduct a thorough evaluation of the available information. An ACO's review request may also serve to alert CMS to a larger issue, which could be solved in a more timely and efficient manner than one discovered years down the road.

MIPS Proposals

Replacing the MIPS APM Scoring Standard with the APP
Proposals: CMS proposes to not move forward with the MIPS Value Pathways (MVP) approach for 2021 due to the strains placed on the health care system related to the COVID-19 pandemic. Instead the agency continues to solicit feedback on the guiding principles for implementing the MVP in 2022 at the earliest.

CMS also proposes to sunset the MIPS APM Scoring Standard, the scoring method currently used for ACOs in MIPS, starting in 2021. Instead, CMS proposes to replace the MIPS APM Scoring Standard with the new APP, which would also be used to score MSSP ACO quality for purposes of the MSSP.

Comments: As noted in our detailed comments regarding the proposed ACO quality changes and the APP above, NAACOS opposes CMS removing the APM Scoring Standard. Just as CMS has delayed moving forward with the MVP due to the significant changes it would require while clinicians continue to grapple with the affects and uncertainty caused by the COVID-19 pandemic, CMS should not move forward with proposed structural changes to the way all APMs are scored in MIPS. The proposed APP attempts to apply one approach to a multitude of providers and APMs. The current MIPS APM Scoring Standard, in comparison, allows each APM to have its own set of unique quality measures and scoring approaches that best fit a particular model. This approach allows specific APMs to have meaningful quality measures tailored to their model's goals while still providing credit for quality improvement efforts to those who are also subject to MIPS. The proposed APP approach would instead apply one set of quality measures for all APMs subject to MIPS. Therefore, each model participant would need to report not only their APM's specific quality measures, but the APP quality measures (or other measures) as well. This one size fits all approach results in more burden for APM participants and further may require the model participants to report on measures that are not applicable or appropriate. Finally, NAACOS has concerns that this policy, which may allow APMs to choose to select measures to report outside the APP instead of relying on the APM's own quality measures as is currently done, would allow certain organizations to select measures for which they have the highest historical performance, not allowing for a true and fair assessment of quality improvement efforts. We instead urge CMS to maintain the APM Scoring Standard approach.

We refer CMS to our detailed comments on the proposed ACO quality changes in this letter, which provide feedback on the proposed APP structure, quality measures, benchmarks and exceptions in place for 2020 and 2021 scoring.

Allowing Individual Clinicians and Groups the Option of Choosing to Report Outside the ACO for Purposes of MIPS Analysis
Proposals: CMS proposes to allow individual clinicians and group TINs the option of choosing to report outside the ACO for purposes of MIPS analysis. Should a practice or clinician choose this option, it would be required to select the appropriate measures and reporting method and report separately from the ACO for purposes of MIPS scoring. In this case, these clinicians/groups would only be provided with 50 percent automatic credit for improvement activities (while ACOs are awarded with full points automatically for this performance category). CMS would then award clinicians with the higher of their own scores or the ACO's score for MIPS.

Comments: NAACOS has concerns that this policy would allow certain organizations to select measures for which they have the highest historical performance, not allowing for a true and fair assessment of quality improvement efforts. Additionally, this could cause more complexity and confusion to an already

very complicated process. We instead urge CMS to maintain the APM Scoring Standard approach, under which ACOs would be evaluated on MSSP quality measures for MIPS.

Reweighting/Exceptions for COVID-19 for APM Entities Subject to MIPS

Proposals: CMS proposes to allow an APM Entity to submit a MIPS hardship exception on behalf of all participants in the APM beginning with PY 2020. The request for reweighting would apply for all four MIPS performance categories and for all clinicians in the group subject to MIPS. If an APM Entity, such as an ACO, submits a hardship exception, CMS would not use any data submitted and the APM Entity would receive a neutral MIPS score and payment adjustment for the performance year. Additionally, APM Entities must demonstrate in their application to CMS that greater than 75 percent of participant MIPS eligible clinicians would be eligible for reweighting the Promoting Interoperability (PI) performance category for the applicable performance period.

Comments: NAACOS supports CMS proposals to allow an APM Entity, such as an ACO, to submit a MIPS hardship exception on behalf of all participants in the APM, as previously advocated for by NAACOS. We also urge CMS to provide additional detail regarding what information an ACO would need to provide in order to demonstrate that 75 percent of its participants would be eligible for reweighting of the PI performance category.

Awarding a MIPS Score When a Clinician has Multiple Final Scores Associated with a Single TIN/NPI Combination

Proposals: CMS proposes to use the following hierarchy to assign a final score in instances when a clinician has multiple final scores associated with a single TIN/NPI combination: first a Virtual Group final score; and second the highest available score from an APM Entity (such as an ACO), group and/or individual clinician.

Comments: Currently, CMS uses the following hierarchy to award a final score in these instances: first an APM Entity score (highest score if multiple exist); second a Virtual Group final score; and third a group or individual clinician score (whichever is higher). Therefore, NAACOS feels this proposed policy change would de-emphasize the role of the ACO and would cause additional complexity and confusion. We urge CMS to instead maintain the current policy for awarding a MIPS score when a clinician has multiple final scores associated with a single TIN/NPI combination. Further, CMS should avoid making drastic changes to scoring approaches annually, as this causes additional complexity, confusion and need for more education.

Conclusion

In conclusion, we appreciate the opportunity to comment on these proposals. NAACOS looks forward to working with CMS to implement the changes we have recommended to ensure the continued success of ACOs.

Sincerely,

Clif Gaus, Sc.D.
President and CEO
NAACOS