August 21, 2017

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

Re: (CMS-522-P) Medicare Program; CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments on the proposed rule further implementing the Medicare Access and CHIP Reauthorization Act (MACRA), *Medicare Program; CY 2018 Updates to the Quality Payment Program,* published in the *Federal Register* on June 30, 2017.

NAACOS is the largest association of ACOs, representing more than 3.7 million beneficiary lives through more than 240 Medicare Shared Savings Program (MSSP), Next Generation, and commercial ACOs. NAACOS is an ACO member-led and member-owned non-profit organization that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health and outcomes, and health care cost efficiency. Our members, more than many other healthcare organizations, want to see an effective, coordinated patient-centric care process. Our recommendations reflect our expectation and desire to see ACOs achieve the long-term sustainability necessary to enhance care coordination and health outcomes for Medicare beneficiaries, reduce healthcare costs, and improve quality in the Medicare program.

Summary of Key Recommendations

As part of the agency's implementation of the Medicare Access and CHIP Reauthorization Act (MACRA), we urge CMS to:

- **finalize its proposal to maintain the 8 percent Advanced APM revenue-based nominal risk threshold for 2019 and 2020 and not to raise it in future years**
- **finalize the addition of an 8 percent revenue-based nominal risk standard for the All-Payer Combination Option but focus this threshold only on physician revenue**
- **align the Other Payer nominal risk standard with that used for the Medicare Option and not require higher or more complicated risk levels for Other Payer APMs to qualify as Advanced**

- **expedite the All-Payer approach and provide credit for Medicare Advantage (MA) Advanced APM participation as soon as possible using the patient count Qualifying APM Professional (QP) determination**
- **significantly modify the proposed process for qualifying under the All-Payer Combination Option by simplifying and streamlining the process and making determinations at the APM Entity or TIN level rather than the individual clinician level**
- **hold clinicians accountable in the MIPS program in year two and reward high-performing clinicians who have invested heavily in performance improvement and should therefore be rewarded for this investment, time, and effort by incorporating a 10 percent cost score and 33-point performance threshold for MIPS**
- **exclude MIPS payment adjustments as ACO expenditures**
- **adopt an alternative methodology for making quality comparisons in MIPS to create more equitable benchmarks across reporting mechanisms**
- **exclude clinicians meeting ACI re-weighting requirements from the TIN ACI information reported to CMS for ACOs scored under the APM Scoring Standard**
- **finalize its proposal to create a fourth snapshot date to occur on December 31 for purposes of determining which providers are in the ACO's MIPS APM Scoring Standard evaluation**

Advanced APM Recommendations

Advanced APM List

Key Comment:

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

Proposal: CMS anticipates considerable growth in the number of Advanced APMs and the number of clinicians qualifying for Advanced APM bonuses in 2020. The Advanced APM list includes a number of ACO initiatives, including MSSP Tracks 1+, 2 and 3 as well as the Next Generation ACO Model but MSSP Track 1 is not considered by CMS as an Advanced APM.

Comment: We are extremely pleased that a number of ACO models including MSSP Track 1+, 2 and 3 and the Next Generation ACO Model are on the list of 2018 Advanced APMs. These ACOs 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, we urge CMS to reverse its decision and include MSSP Track 1 as an Advanced APM. Track 1 ACOs have been leaders in the transition to value-based payment models and have significantly invested in their development and early success. Excluding these ACOs undermines this important transition, and we strongly recommend CMS include Track 1 MSSP as an Advanced APM.

Advanced APM Risk Requirements

Key comments:

- **NAACOS urges CMS to finalize its proposal to maintain the 8 percent Advanced APM revenue-based nominal risk threshold for 2019 and future years.**

- **Rather than create a separate risk standard for smaller or rural practices, NAACOS urges CMS to reinstate programs that provide up-front assistance to these organizations to enable them to participate in Alternative Payment Models (APMs).**
- **NAACOS requests that CMS lower the Advanced APM benchmark-based risk threshold and remove Part A revenue from the revenue-based threshold.**
- **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.**

Proposals: CMS proposes to maintain the current revenue-based nominal amount standard at 8 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities for the 2019 and 2020 performance periods, rather than raising the threshold as the agency previously discussed. CMS requests comments on whether the agency should create a different, potentially lower, revenue-based nominal risk standard for the 2019 and 2020 performance years for small or rural practices as well as small and/or rural practices that join larger APM Entities in order to participate in APMs.

For an APM to qualify as Advanced, it must meet nominal risk criteria such that the total amount an APM Entity potentially owes CMS or foregoes under an APM must be at least equal to either:

- 8 percent of the average estimated total Medicare Parts A and B revenues of a participating APM Entity (the revenue-based standard); or
- 3 percent of the expected expenditures for which an APM Entity is responsible under the APM (the benchmark-based standard)

CMS policy 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 ECs;
- Reduce payment rates to the APM Entity and/or the APM Entity's ECs; 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.

Comment: In the MACRA statute, Congress 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 Qualifying APM Participant (QP) status. An APM Entity that is accountable for losses of up to 8 percent of 75 percent of its Medicare revenue 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 Medicare revenue 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. Increasing the revenue-based threshold in 2019 or beyond would likely discourage

DRAFT

participation in Advanced APMs. Therefore, we strongly urge CMS to preserve stability and predictability for APMs by maintaining the 8 percent threshold for 2019 and future years.

While we strongly support 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 current policy sets the Advanced APM revenue-based threshold at 8 percent of an APM Entity's Medicare Part A and B revenue. By including Part A revenue, CMS significantly disadvantages APM 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 ACO model. In certain instances, only a small portion of the hospital's Part A revenue may be related to attributed beneficiaries under the ACO. Therefore, the loss sharing limit for the ACO would be based largely on Part A revenue for patients outside the ACO, thus penalizing ACOs with hospital participants by significantly raising their loss sharing limit. We recommend CMS fully analyze the impact of including Part A revenue and publicly release data 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 modify the 8 percent revenue-based threshold by removing Part A revenue and only include an APM Entity's Part B revenue.

We do not feel it is necessary to create a new, likely lower, revenue-based nominal risk standard for small or rural practices. Doing so creates an unnecessary division between practices and creates competition where affected practices may terminate their participation in an ACO or other APM Entity to benefit from lower risk thresholds available to them on their own. This undermines the progress ACOs have made and creates division among providers based on practice size and geography. CMS considers allowing smaller or rural practices that are part of larger APM Entities to qualify, but it is unclear how this would work operationally since risk is set at the ACO model level. A likely outcome of that scenario would be to fragment the organization, which would undermine the ACO as a whole. We do not support creating a separate risk threshold for smaller or rural practices. As an alternative, we recommend CMS reinstate programs such as the Advanced Investment Model, which provided assistance to smaller and/or rural practices seeking to participate in an APM. This approach provides more meaningful assistance by providing upfront funds for these organizations and should be reinstated.

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

We support the options under the financial risk standard, and 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.

As previously advocated by NAACOS, we urge 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 were very disappointed that CMS finalized a policy that 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.

APMs Introduced During the Performance Year

Key comment:

- **NAACOS supports creating an opportunity for new APMs and their related APM entities to qualify for Advanced APM bonuses through an abbreviated performance period.**

Proposal: CMS proposes flexibility to allow new Advanced APMs that start during a performance year to have an opportunity to qualify for Advanced APM bonuses as long as they participate for at least 60 continuous days during the performance period. CMS would modify policies regarding the timeframe for which payment amount and patient count data are included in the QP calculation by determining QP Threshold Scores using only data in the numerator and denominator for the time period that APM Entities participated, as long as it was at least 60 continuous days during the Medicare QP Performance Period, which is January 1 to August 31.

Comment: We support CMS's proposal to provide more flexibility and allow APM Entities to qualify for Advanced APM bonuses through participation in an APM that starts during the Medicare QP Performance Period. This enables new APMs to begin during a performance period and rewards the APM Entities participating in these programs, which is especially important considering the limited number of years the Advanced APM bonus is available.

Eligible Clinicians Participation in Multiple Advanced APMs

Key comment:

- **NAACOS recommends CMS not finalize its proposal to disqualify ECs participating in multiple Advanced APM entities from being eligible for Advanced APM bonuses based on an APM Entity terminating during the performance period.**

Proposal: CMS proposes to amend its regulations to make clear that if an eligible clinician (EC) is determined to be a QP based on participation in multiple Advanced APMs but any of the APM Entities in which he or she participates voluntarily or involuntarily terminates from the Advanced APM before the end of the Medicare QP Performance Period, the EC is not a QP.

Comment: We do not support CMS's proposal which would unfairly penalize providers that may otherwise qualify for the Advanced APM bonus. Since ECs are only evaluated using participation in multiple Advanced APMs if none of their corresponding Advanced APM Entities meet the QP thresholds as a collective entity, this situation may not happen frequently in the early years of the program. However, as the QP thresholds rise, this situation will be more common. In these instances, we recommend CMS remove from the QP calculation the APM Entity that terminates from its program but still calculate the QP threshold for the EC using its other APM Entity participation. This appropriately removes the APM Entity that terminates while still allowing an opportunity for the EC to attain QP status.

Medical Home Model Size Restrictions

Key Comment:

- **NAACOS urges CMS to change the policy prohibiting ACO primary care practices selected for CPC+ to be eligible for the Advanced APM bonus.**

Proposal: CMS proposes to modify its requirement that beginning with the 2018 performance period the Medical Home Model risk standard would only apply to APM Entities with fewer than 50 ECs. CMS proposes to remove the size limit requirement for practices in Comprehensive Primary Care Plus (CPC+) Round 1 qualifying for the Advanced APM bonus. Therefore, the agency would allow primary care practices participating in Round 1 of CPC+ to remain eligible for the Advanced APM bonus in 2020 regardless of their practice size or relationship to a parent organization.

Comment: Under current CMS policy, MSSP Track 1 primary care practices are not eligible for Advanced APM bonuses based on their Track 1 or CPC+ participation. NAACOS has repeatedly raised concerns about this policy. It is problematic that while CMS allows MSSP Track 1 primary care practices to participate in CPC+ the agency does not allow them to qualify for the Advanced APM bonus based on their MSSP or CPC+ participation. This makes little sense as these providers are participating in two of CMS's premier APMs, one of which is included on the Advanced APM list. The unintended consequence of withholding the Advanced APM bonus from these practices is to incentivize them to

leave their ACO to participate in CPC+ on their own and earn the Advanced APM bonus. By putting primary care practices in this either/or position, CMS slows the adoption of accountability for total cost of care, which is the greatest opportunity to bend the cost curve. We urge CMS to change its policy and allow MSSP Track 1 primary care practices selected for CPC+ to be eligible for the Advanced APM bonus.

Qualifying APM Participant (QP) and Partial QP Determination

Key Comment:

- **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.**

Under existing program rules, 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 2018 in mid-June 2017). Only providers on that list are included for Advanced APM bonuses for the following performance year.

Comments: If a physician joins the Next Generation ACO July 1, 2017, he or she would be ineligible to receive an Advanced APM bonus until 2021. A three-and-a-half-year delay for a provider actively engaged in an 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 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.**

CMS finalized a general policy that an Advanced APM require at least 50 percent of ECs use certified health IT functions as outlined in the definition of CEHRT. There is a slight modification for ACOs that acknowledges the existing MSSP requirements for CEHRT through reporting ACO measure 11 (Use of Certified EHR Technology). Through the alternative criteria finalized for ACOs, they meet the CEHRT use requirement if the APM Entity applies a financial penalty or reward based on the degree of their eligible clinicians' use of CEHRT, and MSSP ACOs currently meet this requirement through ACO measure 11. Since the Next Generation ACO Model does not include the same measure 11, it is unclear exactly how CMS evaluates whether Next Generation ACOs meet the CEHRT requirement.

*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, there is confusion about specifically what is required of Next Generation ACO providers to meet the CEHRT criteria. The agency has repeatedly said details on this are forthcoming, but confusion and uncertainty remains. We urge swift clarification so that Next Generation ACOs can 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 that are not beneficial for providers and cause 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. We have repeatedly seen that vendors are not ready to meet new criteria as they evolve, 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.

All-Payer Combination Option

Performance Period and Risk Criteria

Key comments:

- **NAACOS urges CMS to expedite the All-Payer approach and provide credit for Medicare Advantage (MA) Advanced APM participation as soon as possible using the patient count QP determination.**
- **NAACOS supports CMS's proposed addition of an Other Payer revenue-based nominal risk standard but urges the agency to focus this threshold only on physician revenue**
- **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.**

Proposals: While Advanced APMs are only evaluated based on traditional Medicare in the early years of the Quality Payment Program (QPP), beginning with the 2021 payment adjustment year CMS will give ACOs and other APM Entities credit for qualifying APM participation with payers outside of Medicare, including MA, Medicaid and commercial plans. While the agency does not propose to change the timing of the All-Payer calculation, CMS acknowledges receiving feedback from stakeholders requesting that the agency modify its previously established timeframe and give credit for MA Advanced APM participation sooner. The agency requests comments on this.

CMS proposes a number of details on how the process for the All-Payer Combination Option would work, including an All-Payer QP Performance Period beginning January 1 and ending June 30 of the calendar year that is two years prior to the payment year. CMS proposes to add a revenue-based nominal risk standard of 8 percent, which matches the revenue-based standard for Medicare Advanced APMs.

Comments: Developing a robust All-Payer Combination Option to allow clinicians to qualify for Advanced APM bonuses will be especially important as the QP thresholds become increasingly challenging in future program years. As detailed in a previous letter to CMS, we urge the agency to alter its regulations to allow clinicians' contracts with MA plans that meet the risk, quality and certified electronic health information technology (CEHRT) requirements to be included as part of the QP determination beginning with the 2019 payment adjustment year. We believe this could be accomplished within the statutory constraints by modifying the patient count determination of QP status, thus allowing ACOs and other APM Entities another opportunity to qualify for the 5 percent Advanced APM bonus in 2019 and 2020 if they do not meet the QP thresholds based on Medicare Advanced APM participation alone. Specifically, CMS could test clinicians' satisfaction of the Medicare fee-for-service (FFS) revenue and beneficiary thresholds first. If a clinician or group of clinicians pass,

then they do not need to proceed to the next steps of the test. If they do not pass, then CMS could proceed to test Medicare FFS and MA together for a second stage of the beneficiary count test. We also urge CMS to similarly expedite the overall process to give credit for APM participation with other payers including Medicaid, commercial and CMS multi-payer arrangements. The Advanced APM bonus is only available for a few years and it is essential CMS expedite implementation of the All-Payer Combination Option so it is broadly available for providers dedicated to value-based care and payment.

We strongly support CMS developing a revenue-based standard for Other Payer APMs and aligning that standard with what is used for Advanced APMs under the Medicare Option. This standard would allow Other Payer APMs with risk levels based on revenue to qualify as Advanced and would be in addition to the benchmark-based risk standard CMS previously finalized. There is an ongoing evolution of APM arrangements in commercial markets with risk based on revenue or total expenditures, and it is important to allow either type of risk arrangement to qualify as meeting nominal risk standards. We request CMS finalize the Other Payer revenue-based standard. However, as explained earlier in this letter we urge CMS to focus the revenue-based threshold only on physician revenue. We urge the same approach for both Medicare and Other Payer revenue-based standards.

While modifying the Other Payer nominal risk standard to add a revenue-based standard, we urge CMS to revise previously finalized requirements related to minimum loss rates and shared loss rates. Specifically, we request the agency remove requirements that, except for Medicaid Medical Home Models, a qualifying Other Payer risk arrangement must have a marginal risk rate of at least 30 percent of losses in excess of expected expenditures and a minimum loss rate at or below 4 percent. CMS did not finalize its proposed marginal risk rates or minimum loss rates for Advanced APMs under the Medicare Option and should therefore not do so for Other Payer Advanced APMs. The agency provides no evidence that these thresholds are appropriate or reflect the amount of risk that is typically required in Other Payer APM agreements. 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). We urge CMS to survey payers outside on their APM risk arrangements and share that information with stakeholders. We see no reason that the risk thresholds for these payers should be higher or more complicated than what is required for Advanced APMs under the Medicare Option.

Further, research on physician participation in new payment models has found that the need to manage multiple and conflicting requirements from different payers is a strong disincentive to broader participation in these models and can also reduce the ability of physicians to improve quality and reduce spending. Different goals, quality metrics, performance feedback reports, payment models, benchmarks, and attribution and risk adjustment methods increase the time and costs that organizations must spend on administrative activities rather than on patient care. CMS itself has urged alignment of payment structures in the multi-payer models that it has created. Consequently, we recommend that the agency establish the same financial risk requirements for all Advanced APMs regardless of payer in order to facilitate the development of multi-payer models.

We support the proposed All-Payer Performance Period of January 1 through June 30. A shorter performance period for Other Payers is warranted given that it will take longer to collect the relevant data and run the calculations comparatively to Medicare. However, we recommend that CMS also include an option for a partial All-Payer Performance Period to accommodate providers entering into new contracts during the performance year. CMS proposes this flexibility for the Medicare Option and should do so with the All-Payer Option as well.

Process for Qualifying for All-Payer Advanced APM Participation

Key Comments:

- **NAACOS urges CMS to dramatically minimize administrative burdens for providers to demonstrate their APM participation with Other Payer APMs.**
- **NAACOS urges CMS to significantly modify the proposed process for qualifying under the All-Payer Combination Option by simplifying and streamlining the process and making determinations at the APM Entity level or TIN rather than the individual clinician level.**

Proposals: In order for CMS to evaluate and subsequently give credit for ACO/clinician participation with Other Payer Advanced APMs, the agency proposes a process to first determine whether a specific Other Payer APM arrangement meets the required criteria for it to be considered an Advanced APM. CMS would approve Other Payer APMs based on those submitted for review by the agency. The reviews could be requested in a number of ways such as through a payer-initiated process where the payer submits information to CMS or through a process where information is submitted by ECs or APM Entities such as ACOs. The agency notes it will develop forms detailing what information would be required as part of these requests, and the process would be voluntary for those requesting review. There are different evaluation standards for Medicaid APMs to qualify as Other Payer APMs, and there would be a different review process as well. CMS also proposes that a state could request determinations for its Medicaid FFS and Medicaid managed care plan payment arrangements. CMS proposes to phase in its All-Payer approach in the 2019 and 2020 performance periods, with the first submissions for 2019 performance occurring as early 2018.

CMS proposes that Other Payer Advanced APM determinations would be in effect for only one year at a time. Therefore, payers and providers would have to go through the Other Payer Advanced APM process annually, including submission of detailed information about the APM arrangement and information about revenue and patient counts necessary to make a QP determination. CMS proposes that APM Entities and ECs who submit complete Eligible Clinician Initiated Submission Forms by September 1 of the calendar year of the relevant All- Payer QP Performance Period would receive CMS's Other Payer Advanced APM determination prior to December 1.

CMS explains that it may be challenging for ECs to submit information sufficient for the agency to determine that at least 50 percent of ECs under the Other Payer arrangement are required to use CEHRT to document and communicate clinical care. To address this issue, CMS proposes that the agency would presume that an Other Payer arrangement would satisfy the 50 percent CEHRT use criterion if CMS receives information and documentation showing that the Other Payer arrangement requires the requesting EC(s) to use CEHRT to document and communicate clinician information.

Comments: The process CMS proposes to determine Other Payer Advanced APM participation is prohibitively complicated. The extensive proposed process is an example of government overreach and places a significant regulatory burden on payers and providers and needs to be dramatically simplified. Without significant modification, the weight of the regulatory burden will likely cripple any meaningful participation in the All-Payer Combination Option. CMS needs to entirely re-evaluate its proposed process and implement a more streamlined and efficient process for providers to qualify for Advanced APM bonuses through the All-Payer Combination Option. As part of a revised approach we urge CMS to:

- Require MA and state Medicaid agencies to submit information to CMS on their APM payment arrangements. Medicaid managed care plans should also have an opportunity to submit information directly to CMS. If CMS is truly committed to advancing value-based payment,

submission of this information by payers that work closely with the agency should not be voluntary. This would also alleviate duplicative information collection and submission by multiple providers.

- Evaluate Other Payer participation at the APM Entity or TIN level, not at the EC level as proposed. Evaluating the APM Entity or TIN as a whole is necessary to give diverse providers within an organization one determination, thus reinforcing the collective focus and mission of the organization and not fragmenting its providers by only allowing some to qualify for Advanced APM bonuses under the All-Payer Combination Option.
- Remove the proposed requirement that Other Payer APM arrangements submit information and be approved annually. This is unnecessary and creates added work for all involved. As an alternative, CMS should require a simple attestation annually to confirm no material changes have occurred that would change the Other Payer Advanced APM determination.
- Ensure the timing of the Other Payer determinations allow enough time for CMS to alert providers of their determination so they are able to report under MIPS if necessary.
- For the purposes of QP determinations, only require APM Entities or TINs to submit information and be evaluated on Other Payer arrangements that are Advanced. The QP numerator and denominator should only include information from payers offering and contracting with providers for Other Payer Advanced APM participation, not participation in all Other Payer payment arrangements including those that are not Advanced.

In addition to our recommendation above related to requiring MA plans and state Medicaid agencies to submit information on their APM payment arrangements, CMS should develop a public website where the agency lists payers and their specific payment arrangements that are under review for Other Payer Advanced APM determination. While the agency should not include proprietary information about these arrangements, it would be helpful for providers to know what is under review. This would promote transparency and would be in addition to a public website listing the Other Payer arrangements approved by the agency as Advanced APMs. This information is necessary for providers so they know on an ongoing basis which payment models are being reviewed by CMS and which are approved. This would help as providers consider and negotiate APM participation with payers outside of Medicare. Further, should CMS not finalize our recommendation to require MA plans and state Medicaid agencies to submit information about APMs, it would be necessary so providers could avoid collecting and submitting information to the agency when it would be redundant from what is already being reviewed.

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

CMS's proposal related to demonstrating CEHRT requirements illustrates the need to base Other Payer APM participation at the APM Entity or TIN level rather than the individual EC level. Accountability for a range of quality measures, assuming risk, and implementing CEHRT are not done at the individual provider level, but at the organizational/APM Entity level. It makes little sense for CMS to propose such a different approach for Other Payer APMs than for Medicare APMs, which evaluate APM participation at the APM Entity level. It also adds a considerable amount of complexity and confusion to the process. We urge CMS to evaluate Other Payer APM participation at the APM Entity or TIN level. We support CMS presuming that an Other Payer arrangement would satisfy the 50 percent CEHRT use criterion if

CMS receives information showing that the Other Payer arrangement requires the use CEHRT to document and communicate clinician information. We urge CMS to use attestation rather than require submission of detailed documentation.

According to a question and answer during a CMS QPP webinar on July 18 for the All-Payer Combination Option, if an ACO has commercial contracts with four payers (ex. A, B, C and D), information about all four payment arrangements would be used in the numerator and denominator to calculate the QP determination. This would be the case even if payers C and D do not offer any Advanced APM opportunities. Therefore, ECs/APM Entities would have to collect and submit detailed information on all payment arrangements that they participate in, which as proposed is very burdensome. However, the effect of including all payers in the All-Payer QP numerator and denominator is even more troubling than the administrative burden created by having to collect and submit this information. If a payer chooses not to offer an Advanced APM opportunity, but providers are held accountable for that by including that in the QP denominator, providers are penalized for something outside of their control. It diminishes their ability to qualify as QPs even if they are actively participating in Other Payer Advanced APMs with all payers with whom they contract who offer those opportunities. Therefore, we urge CMS to only include an APM Entity's Other Payer Advanced APMs in the numerator and denominator of the All-Payer Combination Option QP calculation.

We support CMS's proposal to remove the previously finalized requirement that plans must verify information submitted by clinicians. That policy places an added burden on payers and the agency, and it is unnecessary if providers are attesting to the accuracy of the information submitted.

Calculation and Payment of APM Bonus

Key Comments:

- **NAACOS urges CMS to 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 an ACO.**
- **NAACOS recommends including ACO shared savings payments as supplemental service payments in the calculation of the APM incentive payment amount.**

CMS will 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 EC 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.

It is CMS policy to only include supplemental service payments in the calculation of the Advanced APM Incentive Payment amount if they meet certain criteria. CMS finalized a policy that ACO shared savings payments do not qualify as supplemental service payments and are therefore not included in the calculation of Advanced APM bonuses.

Comments: We strongly recommend 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.

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.

MIPS Recommendations

Proposed Performance Threshold

Key Comments:

- **NAACOS is concerned that CMS's proposals to exempt additional clinicians and dilute performance requirements in year two of the MIPS program will discourage those clinicians who have already made a commitment to value-based care and invested time and resources towards making the shift to value-based care. We urge CMS to hold clinicians accountable in the MIPS program in year two and reward high-performing clinicians who have invested heavily in performance improvement and should therefore be rewarded for this investment, time, and effort.**
- **NAACOS urges CMS to begin holding clinicians accountable for cost and quality by incorporating a 10 percent cost score and 33-point performance threshold for MIPS.**

Proposal: CMS proposes to increase the MIPS performance threshold from three points to 15 points, while maintaining the 70-point threshold for exceptional performance. Alternatively, CMS proposes to lower the performance threshold even further to six points or raise the threshold to 33 points. Additionally, CMS proposes to maintain a 0 percent weight for the cost performance category in MIPS. As a result of these policies, CMS estimates approximately 96 percent of MIPS ECs will receive a positive or neutral payment adjustment. Therefore, positive payment adjustments for high performers are expected to be minimal. CMS also proposes changes to the low volume exception criteria, which will exclude additional clinicians from the MIPS program if finalized. Specifically, CMS proposes to increase the exemption threshold from $30,000 or 100 or fewer Medicare patients to $90,000 or 200 or fewer Medicare patients seen in the measurement period. CMS estimates this will exclude an additional 585,560 clinicians from the MIPS program. The total impact of these changes has the potential to reduce the opportunities for bonus payments in MIPS due to the budget neutrality requirements of the program.

Comment: NAACOS is concerned that CMS's proposals to exempt additional clinicians and dilute performance requirements in year two of the MIPS program will discourage those clinicians who have already made a commitment to value-based care and invested time and resources towards making the shift to value-based care. Instead, CMS should reward high-performing clinicians who have invested heavily in performance improvement and should therefore be rewarded for this investment, time, and effort. We therefore support CMS's alternative proposals to set the performance threshold at 33 points and to hold MIPS ECs accountable for the cost performance category at a weight of 10 percent. Because CMS is required to incorporate a 30 percent cost performance category by performance year 2019, it would be prudent to apply a phased-in approach rather than subjecting clinicians to such a high standard in 2019 without previously incorporating the cost component in the overall MIPS score. In the 2017 QPP rule CMS proposed to implement a 30 percent cost contribution to the overall MIPS score in the 2018 performance year, therefore, a phased-in approach of applying a 10 percent

DRAFT

contribution in performance year 2018 is reasonable and necessary to prepare providers. What's more, we feel it is important that CMS continue its commitment to transition providers and Medicare payments to improve the experience of care and the health of populations and reduce per capita costs of health care. If the agency fails to follow-through on this promise, it discourages those who have been pioneers in the commitment to value-based health care and may lose momentum in encouraging those currently progressing along this continuum.

Counting MIPS Payment Adjustments as ACO Expenditures

Key Comment:

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

Proposal: CMS does not propose to reverse course on its policy decision to count MIPS bonuses as ACO expenditures in this regulation. In late May 2017 CMS issued an updated factsheet on the Track 1+ ACO option that clarified "MIPS payment adjustments would be included in ACO expenditures under the current Shared Savings Program's regulations for calculating benchmark and performance year expenditures just as other payment adjustments made on claims under other value based payment programs are incorporated." The agency notes that "advanced APM lump sum incentive payments to qualified participants (QPs) participating in Track 1+ Model ACOs will not be included in ACO expenditures because they are not beneficiary-identifiable payments and are lump sum payments to QPs made outside the claims payment system."

Comment: NAACOS continues to oppose this unfair policy and urges CMS to exclude MIPS payment adjustments from ACO expenditure calculations. The current framework CMS has established will punish ACOs for their high performance in MIPS. As stated in our comment letter above, NAACOS believes CMS should recognize Track 1 ACOs as Advanced APMs. However, because CMS continues to subject Track 1 ACOs to MIPS, these ACOs have no choice but to be evaluated under MIPS while continuing their focus on the ACO program goals. Most ACOs will perform well under the proposed MIPS performance criteria and therefore earn minimal bonuses under the program. These bonuses will then count against the ACO when expenditures are calculated for purposes of MSSP calculations. Therefore, the better an ACO and its ECs perform in MIPS, the greater they will be penalized when calculating shared savings/losses for the ACO. This is an unfair and untenable policy, and CMS must modify its position to exempt MIPS payment adjustments as expenditures in the ACO program. Although CMS argues that the agency has maintained this policy under the Value-Based Payment Modifier program, NAACOS believes CMS has the authority and ability to remove MIPS expenditures from ACO benchmark calculations. In fact, CMS does make claim level adjustments by adding sequestration costs back to paid amounts when calculating ACO expenditures. It was not the intent of Congress to penalize ACOs in MIPS, and therefore CMS must alter this policy to continue encouraging provider participation in the Track 1 ACO program.

MIPS APM Scoring Standard, Assigning Quality Points Based on Benchmarks

Key Comment:

- **NAACOS urges CMS to adopt an alternative methodology for making quality comparisons in MIPS to create more equitable benchmarks across reporting mechanisms.**

Proposal: CMS does not propose to change the way points are assigned in the quality performance category. As was the case in PY 2017, CMS proposes to score quality measure performance under the APM scoring standard using a percentile distribution, separated by decile categories. For each

benchmark, CMS will calculate the decile breaks for measure performance and assign points based on the benchmark decile range into which the APM Entity's measure performance falls. CMS proposes to continue to use a graduated points-assignment approach, where a measure is assigned a continuum of points out to one decimal place, based on its place in the decile.

Comment: The current methodology for comparing quality scores in MIPS results in unfair comparisons, providing an advantage to those using reporting methods for which the provider or organization can cherry pick patients to report on and have a lower benchmark to compete against. For example, as demonstrated in example one below the benchmarks for the Breast Cancer Screening Measure vary greatly depending upon the reporting mechanism used. To earn the highest score for this measure, a clinician must earn greater than or equal to 73.23 for electronic health record (EHR) reporting, 87.93 for registry/Qualified Clinical Data Registry (QCDR) reporting, and 100 for Group Practice Reporting Option (GPRO) Web Interface reporting. Similarly, as shown in example two below, for the Colorectal Cancer Screening measure a clinician must earn greater than or equal to 82.29 for EHR reporting, 88.15 for registry/QCDR reporting, and 100 for GPRO Web Interface reporting.

Example 1: Breast Cancer Screening Measure Benchmarks by Submission Method

Measure	Submission Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Breast Cancer Screening (112)	EHR	12.41-22.21	22.22-32.30	32.31-40.86	40.87-47.91	47.92-55.25	55.26-63.06	63.07-73.22	≥73.23
Breast Cancer Screening (112)	Registry/QCDR	14.49-24.52	24.53-35.70	35.71-46.01	46.02-55.06	55.07-63.67	63.68-74.06	74.07-87.92	≥87.93
Breast Cancer Screening (112)	GPRO Web Interface	30	40	50	60	70	80	90	100

Example 2: Colorectal Cancer Screening Measure Benchmarks by Submission Method

Measure	Submission Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Colorectal Cancer Screening (113)	EHR	7.35-15.97	15.98-24.66	24.67-33.45	33.46-44.39	44.40-56.19	56.20-67.91	67.92-82.28	≥82.29
Colorectal Cancer Screening (113)	Registry/QCDR	10.08-20.68	20.69-32.73	32.74-45.20	45.21-55.95	55.96-66.31	66.32-77.01	77.02-88.14	≥88.15
Colorectal Cancer Screening (113)	GPRO Web Interface	30	40	50	60	70	80	90	100

DRAFT

Therefore, we urge CMS to adopt an alternate methodology for making quality comparisons in MIPS. The first potential solution would be to have a common mean and separate standard deviations for each reporting mechanism (registry, QCDR, EHR, Web Interface). Alternatively, CMS could lower the GPRO Interface mean for purposes of MIPS, scoring to either the lower of the GPRO mean or the average of the EHR and Registry/QCDR mean. The assignment of deciles could then be based on a bell curve of all GPRO reporters for each measure. These alternative policies are needed to ensure truly fair comparisons in quality for MIPS. Making more accurate comparisons across reporting methods will also be important in the context of making comparisons with publicly reported data for MIPS and other programs evaluating cost. It is critical that CMS establish a fair way to compare reporting mechanisms, otherwise certain performance will be inflated due solely to the clinician or group's choice of reporting method.

MIPS APM Scoring Standard, Including a Fourth Snapshot Date

Key Comment:

- **NAACOS supports the addition of a fourth snapshot date to occur on December 31 for purposes of determining which providers are in the ACO's MIPS APM Scoring Standard evaluation.**

Proposal: CMS proposes to include a fourth snapshot date to determine which ECs are participating in the ACO for purposes of MIPS APM Scoring Standard evaluation beginning in PY 2018. This additional snapshot date would occur on December 31 to ensure that an EC who joins an ACO TIN late in the performance year would be scored under the APM Scoring Standard along with the rest of the ACO. The remaining snapshot dates will also continue to be in place (March 31, June 30, and August 31).

Comment: NAACOS strongly supports the addition of a fourth snapshot date to occur on December 31. This revised policy will alleviate concerns NAACOS has communicated regarding the challenges presented by adding providers late in the year who are not included in the ACO's MIPS APM Scoring Standard score. As detailed in our previous comments, when clinicians are added after the final snapshot date, the ACO must arrange for separate reporting of quality measures in MIPS and will receive a separate MIPS score and resulting payment adjustment. This creates confusion and isolates the clinician from the ACO entity and its program goals. This proposed policy will resolve this problem and allow ACOs to focus on quality and improvement activities as a cohesive unit for both the ACO and MIPS programs.

MIPS APM Scoring Standard, Quality Performance Category Changes

Key Comment:

- **NAACOS supports the addition of the CAHPS for ACOs survey measure in the MIPS APM Scoring Standard quality calculations.**

Proposal: CMS proposes to add the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for ACOs survey measure in the MIPS quality performance score analysis for performance year (PY) 2018. Most questions in the CAHPS for ACOs survey can also be found in the CAHPS for MIPS survey except for one question ("Between Visit Communication") that CMS feels is inappropriate for use by ACOs and will therefore not be included in the ACO's MIPS quality score.

Comment: NAACOS supports the addition of this measure for ACO quality performance category evaluation of the MIPS APM Scoring Standard to maintain consistency in the measure set used for ACO

programs and MIPS. Eight measures are currently included in the CAHPS for ACOs survey: ACO-1: CAHPS: Getting Timely Care, Appointments, and Information; ACO-2: CAHPS: How Well Your Providers Communicate; ACO-3: CAHPS: Patients' Rating of Provider; ACO-4: CAHPS: Access to Specialists; ACO-5: CAHPS: Health Promotion and Education; ACO-6: CAHPS: Shared Decision Making; ACO-7: CAHPS: Health Status / Functional Status; ACO-34: CAHPS: Stewardship of Patient Resources. Therefore, we support the exclusion of the "Between Visit Communication" survey question for ACOs' evaluation in MIPS as ACOs do not currently utilize this measure.

MIPS APM Scoring Standard, Advancing Care Information Exclusions

Key Comment:

- **NAACOS urges CMS to exclude patients meeting ACI re-weighting requirements from the TIN ACI information reported to CMS.**

Proposal: CMS makes a clarification that the agency will aggregate Advancing Care Information (ACI) Tax Identification Number (TIN) performance for those using the group reporting option, regardless of ECs meeting certain exemptions for a re-weighting of this performance category such as non-patient facing, non-physician practitioner, or hospital-based or Ambulatory Surgical Center (ASC) exceptions. Specifically, on page 30079 CMS states "the data submission criteria for groups reporting advancing care information performance category described in the Calendar Year 2017 QPP final rule state that group data should be aggregated for all MIPS eligible clinicians within the group practice. This includes those MIPS eligible clinicians who may qualify for a zero percent weighting of the advancing care information performance category due to circumstances as described above such as a significant hardship or other type of exception, hospital-based or ASC-based status, or certain types of non-physician practitioners (Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists and Clinical Registered Nurse Anesthetists)."

Comment: NAACOS urges CMS to exclude clinicians meeting ACI re-weighting requirements ("special status") from the TIN ACI information reported to CMS. ACOs must use the group ACI reporting option for each ACO participant TIN. These scores are then averaged to come up with one ACO-entity level ACI performance category score. Because ACOs are required to have TINs report ACI data to CMS, they should not be unfairly penalized by having to include these scores which could otherwise be excluded. Many of these clinicians were not previously required to participate in the legacy program, Meaningful Use, and will find very few measures applicable to report in ACI. ACO TINs could determine the re-weighting exemption status of their clinicians using the QPP lookup tool and exempt those clinicians from the TIN's ACI data reported to CMS. We urge CMS to clarify that ACOs are not required to include ACI information for those clinicians who meet re-weighting/special status criteria.

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

DRAFT

MIPS APM Scoring Standard, Improvement Activities

Key Comment:

- **NAACOS supports CMS's proposal to continue to provide ACOs with full credit in the Clinical Practice Improvement Activities performance category.**

Proposal: CMS proposes to provide ACOs with full credit (40 points) for the Clinical Practice Improvement Activities (CPIA) performance category for the 2018 performance year. CMS proposes that ACOs and/or their MIPS ECs (or TINs) participating in the MIPS APM will not need to submit data for the improvement activities performance category in order to receive full CPIA credit.

Comment: NAACOS supports CMS's decision to continue to provide ACOs with full credit in the Improvement Activities performance category of the MIPS APM Scoring Standard. We are pleased to see CMS continue this policy, giving automatic credit to ACOs for the work they are already doing in this area on a daily basis inherently in their participation through the ACO. It is critical that CMS continue to find ways to reduce reporting burdens on ACOs to allow them to continue focusing on their ACO program goals.

Complex Patient Bonus

Key Comment:

- **NAACOS supports the addition of bonus points for those treating a high proportion of complex patients. We recommend CMS rely on HCC risk scores to make these determinations.**

Proposal: CMS proposes to add a bonus opportunity for those seeing a large proportion of high-risk patients. CMS proposes using average hierarchical condition category (HCC) risk scores or, alternatively, dual eligible status to determine the proportion of high-risk patients being seen by the practice. Under the HCC calculation CMS proposes for MIPS APMs, including ACOs, CMS would use the beneficiary weighted average HCC risk score for all MIPS ECs, and if technically feasible, CMS would use TINs for models that rely on complete TIN participation such as the MSSP. CMS would calculate the weighted average by taking the sum of the individual clinician's (or TIN's as appropriate) average HCC risk score multiplied by the number of unique beneficiaries cared for by the clinician and then divide by the sum of the beneficiaries cared for by each individual clinician (or TIN) in the APM Entity.

Under the dual eligible calculation, CMS would use the average dual eligible patient ratio for all MIPS ECs, and if technically feasible, CMS would use TINs for models that rely on complete TIN participation. CMS would use data on dual-eligibility status sourced from the state Medicare Modernization Act (MMA) files, submitted by each state to CMS with monthly Medicaid eligibility information analyzing claims from September 1, 2017 to August 31, 2018. CMS would multiply the dual eligible ratio by five points to calculate a complex patient bonus for each MIPS EC.

Comment: NAACOS supports providing credit to those seeing a high proportion of complex patients. We recommend CMS utilize the proposed average HCC risk score methodology to determine eligibility for this bonus. NAACOS has identified issues with the current system of identifying dually eligible patients using status sourced from the state MMA files. These concerns lead us to believe that using the average dual eligible method would lead to inaccuracies. We therefore strongly recommend CMS utilize the average HCC risk scores to determine the proportion of high-risk patients seen by a practice for purposes of this complex patient bonus calculation.

Conclusion

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

Sincerely,

Clif Gaus

DRAFT