NEXTGEN
ACO COALITION

October 5, 2020

The Honorable Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1734-P
7500 Security Boulevard
Baltimore, MD 21244-8016

Submitted electronically to http://www.regulations.gov

Re: Advanced Alternative Payment Model Provisions in the Medicare Physician Fee Schedule Proposed Rule

Administrator Verma:

The Next Generation Accountable Care Organization (ACO) Coalition represents participants in two-sided risk-bearing alternative payment models (APMs). We appreciate the opportunity to share our views as you continue to revise payment policies under the Medicare Physician Fee Schedule (PFS).

Throughout the COVID-19 pandemic, risk-bearing ACOs have rapidly deployed care coordination and care management services to ensure the safety and wellbeing of their patient populations. ACOs have used their regulatory flexibilities and infrastructure to provide care to patients in new and innovative ways. Important examples of these innovations include:

- Arranging meal delivery services for patients who struggle with food insecurity;
- Scheduling phone and telehealth visits for patients with chronic conditions;
- Connecting patients to community resources to ensure that their health care and behavioral health needs are met during stay-home orders;
- Setting up outreach services for socially isolated seniors;
- Educating patients about preventing exposure, slowing the spread, and accessing the appropriate level of care for testing and treatment of COVID-19, based on their symptoms;
- Setting up drive-through testing, establishing respiratory centers, and purchasing personal protective equipment to limit exposure to COVID-19.

We thank the agency for the COVID-19 flexibilities implemented for ACOs to date. These flexibilities have allowed ACOs to find new ways to provide the highest quality care to patients while reducing health care cost. We look forward to continuing to work with the administration to advance the movement to performance-based risk. We strongly believe that ACOs and risk-bearing models are best positioned to help our nation recover from the pandemic and to build an efficient, high quality delivery system for the future. The COVID-19 pandemic has underscored the vulnerabilities of a fee-for-service (FFS) payment system and the need to transition to more stable and predictable payment mechanisms.

The Medicare PFS Proposed Rule includes several provisions that affect risk-bearing ACOs. Our specific comments on these provisions are provided below:

APM Incentive Payment Provisions

Patient and Revenue Threshold Increases

The Medicare Access and CHIP Reauthorization Act (MACRA) intended to accelerate traditional Medicare's transition from FFS to advanced alternative payment models (APMs) by including a 5% bonus for qualifying participants (QPs). To be bonus eligible, APMs must meet certain criteria related to quality, use of electronic health records, and bearing of financial risk. Advanced APM entities must also meet specific threshold criteria—measured either by their percentage of revenue or patients—to achieve QP status. QP status also allows advanced APMs to forgo participation in the Merit-based Incentive Payment System (MIPS). MACRA's authors designed these thresholds to ensure increasing levels of participation in advanced APMs over time.

MACRA established payment thresholds but also provided *flexibility to the Secretary of HHS to set the patient count thresholds.*[1] CMS subsequently set the patient count thresholds through regulations.[2] To calculate the thresholds, CMS uses a formula that looks at the attributed beneficiary population over the attribution-eligible population (i.e., all beneficiaries that were attributed to the ACO plus those that could have been but were not attributed). To determine the potentially attributable population, CMS includes beneficiaries that have had at least one evaluation and management service furnished by an eligible clinician or group in the APM.

While escalating participation thresholds and the 5% bonus were intended to encourage greater participation in advanced APMs, the experience on the ground has been the opposite. Instead of growing participation, many ACOs are instead removing specialists from their networks to ensure that the ACO can satisfy the thresholds. This problem particularly impacts specialists who participate in total cost of care models. This result is due, in part, to the interplay between the mechanics of ACO attribution models and the threshold calculation formula. Our experience with the thresholds had been that ACOs lack real-time information, details, and accurate files to determine how they are performing against the thresholds. In response, ACOs must make educated guesses with the best available information to try to hit the thresholds. This result is clearly an unintended consequence, as MACRA intended for the thresholds to serve as an incentive for greater APM participation.

These concerns are particularly present for 2021, when the thresholds are set to sharply increase. According to available data, *roughly a third of two-sided risk bearing ACOs* will fall below the thresholds and, therefore, will miss out on their bonus opportunity. We urge CMS to use its regulatory authority to hold the patient count threshold at 2020 levels for 2021, to ensure that APM entities taking the highest levels of financial risk can qualify for the bonus payment as MACRA intended.

CMS Proposes to Exclude Prospectively Aligned Beneficiaries from the Attribution-Eligible Beneficiary Count to Prevent Dilution of the Threshold Score

In the Proposed Rule, CMS specifies that beneficiaries who are prospectively attributed to an APM entity will be excluded from the attribution-eligible beneficiary count for any other APM entity, when

[1] "The Secretary may base the determination of whether an eligible professional is a qualifying APM participant . . . by using counts of patients in lieu of using payments and using the same or similar percentage criteria . . . as the Secretary determines appropriate." Social Security Act, 1833(z)(2)(D).
[2] Note that there are other thresholds for consideration, including partially qualifying participant thresholds.

that beneficiary would be ineligible to be added to the other APM entity's attributed beneficiary list. That is, CMS would remove prospectively aligned beneficiaries from the denominator when calculating the thresholds. The Preamble to the Proposed Rule states that "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*."

We support CMS's proposal regarding prospectively attributed beneficiaries for advanced APMs that use retrospective attribution. However, we believe that this policy *should also apply* to ACOs that use prospective attribution. We urge CMS to clarify the application of this policy in the final rule.

CMS Proposes Targeted Review of QP Determinations

CMS also proposes to establish a targeted review process for certain criteria used to determine QP status. The targeted review would provide an opportunity for eligible clinicians to bring forward clerical errors and to allow CMS to review and make corrections, if warranted. CMS would allow the eligible clinician or APM entity to request targeted review only if they believe in good faith that, due to a CMS clerical error, an eligible clinician was omitted from the list CMS uses to make QP determinations. CMS proposes that decisions based on the targeted review process are final and that there is no further administrative review or appeal or judicial review.

We support the proposed addition of a targeted review process to address specific CMS clerical errors. However, we believe that the ability to request review and remedy errors should be broader than what CMS proposes in this rule.

We believe that the proposed review process will have positive effects for some ACOs and will enable ACOs to pursue accuracy in the threshold calculations. However, we do not believe that the review process will result in widespread positive effects for ACOs trying to hit the incentive payment thresholds, as the structural problems facing these ACOs still exist. Therefore, we encourage CMS to continue to work with the APM stakeholder community to adjust the thresholds so that they achieve their intended result – incentivizing greater participation in risk-bearing payment models.

Quality and Other Reporting Requirements

Proposed Implementation of the APM Performance Pathway (APP)

CMS proposes to revise the Medicare Shared Savings Program (MSSP) quality performance standard effective for performance year 2021 and subsequent performance years. According to CMS, the new APP would streamline reporting requirements for MSSP ACOs and would create a complementary path to the MIPS Value Pathways. Under this proposal, the number of measures ACOs would be scored on would decrease from 23 to 6, and the number of measures on which ACOs would be required to actively report would be reduced from 10 to 3. ACOs would only need to report one set of quality metrics that would satisfy the reporting requirements under both MIPS and the MSSP. The four categories in the proposed APP framework would be weighted as follows: Quality: 50%; Promoting Interoperability: 30%; Improvement Activities: 20%; and Cost: 0%.

Under this proposal, there would be no quality "phase in." All ACOs, regardless of performance year and agreement period, would be scored on all measures in the APP for purposes of the MSSP quality

performance standard. ACOs would receive a score for each measure that meets the data completeness and case minimum requirements. The score would be determined by comparing measured performance to established benchmarks. In addition, ACOs would need to field a CAHPS for MIPS survey and would be measured on two claims-based measures. CMS also proposes to remove the CMS Web Interface from the submission type options.

We urge CMS to delay and reconsider adoption of these changes to the ACO quality and performance measures at this time. While we support the goals of reducing administrative burden, streamlining requirements, and focusing on a smaller number of measures, we are concerned that this proposal will create uncertainty for ACOs and could cause substantial disruption. We are also concerned about the measures selected. In particular, depression screening can be difficult to achieve with the limited access COVID-19 has created. We are concerned that the measures selected need to be viewed through the lens of the current environment. While CMS notes that it is aligning the new APP to the MIPS Value Pathways, we recall that implementation of the MIPS Value Pathways was also delayed. In light of a year of significant disruption for ACOs, their providers, and patients, we ask that CMS hold off on this significant quality program overhaul for at least another year.

While it is not clear from the proposed rule whether these proposed changes would apply to Next Generation ACOs, we urge CMS not to apply these changes to Next Gens. As you know, Next Gen is in its final year. Implementing sweeping changes to reporting systems in the final year would unnecessarily increase burdens for Next Gen ACO participants who instead should be focused on preparing systems and workflow for new models in 2022. The same timing concern applies to Track 1+ ACOs and we would urge you to take those participants into consideration as well.

Shared Savings Program Quality Performance Standard

CMS proposes to increase the level of quality performance that would be required for all ACOs to meet the Medicare Shared Savings Program (MSSP) quality performance standard to the 40th percentile or above across all MIPS Quality performance category scores. The previous standard was achieving the 30th percentile on one measure in each domain.

Additionally, the proposal includes a provision applicable to 2021 and subsequent performance years specifying that ACOs must submit quality data via the APP to satisfactorily report on behalf of the eligible clinicians who bill under the TIN of an ACO participant for purposes of the MIPS Quality performance category.

CMS proposes that to qualify for shared savings, an ACO must meet the minimum savings rate requirements established for the track/level, meet the proposed quality performance standard described in the proposed rule, and otherwise maintain its eligibility to participate in the SPP. For performance years beginning on or after January 1, 2021, if an ACO that is otherwise eligible to share in savings meets the proposed quality performance standard, the ACO will share in savings at the maximum sharing rate according to the applicable financial model (up to the performance payment limit). If the ACO fails to meet the proposed quality performance standard, the ACO would be ineligible to share in savings.

CMS also proposes modifications to the methodology for determining shared losses under Track 2 and the ENHANCED track, to account for the proposed revisions to the quality performance standard. If an ACO fails to meet the quality performance standard as proposed, the shared loss rate would be

60% under Track 2 or 75% under the ENHANCED track.

Again, we urge CMS not to finalize these proposed changes to quality standards at this time. The changes mark a dramatic step-up in the requirements that ACOs would have to satisfy. ACOs need adequate time to measure the impact of these proposals and to determine the effects on their performance in the future.

Finally, we reiterate our earlier request that the 2020 ACO quality performance standard be set at pay-for-reporting across all measures. If CMS implements pay-for-performance measures, quality should be the better of the 2019 national mean, 2019 ACO actual, or the ACO's 2020 actual score. For the remainder of 2020, ACOs will be focused almost exclusively on patient care and limiting the spread of COVID-19. Though CMS has expanded telehealth for Medicare ACOs, many quality measures cannot be properly met in remote settings.

Compliance with the Quality Performance Standard

CMS proposes to modify the introductory text of the compliance requirements to state that CMS will review an ACO's submission of quality measurement data to identify ACOs that are not meeting the applicable quality performance standards. Under the provision, as revised, CMS would retain the discretion to request additional documentation from an ACO, ACO participants, or ACO providers/suppliers.

CMS also proposes that ACOs exhibiting a pattern of failure to meet the quality performance standard be terminated from the program. More specifically, CMS would terminate an ACO if it fails to meet the quality performance standard for two consecutive performance years within an agreement period, or for any three performance years within an agreement period (even if non-consecutive). For ACOs seeking to renew their agreement or re-enter the program, this assessment would include the last performance year of the ACO's previous agreement period, and would include the two consecutive performance years across the two agreement periods (the last performance year of the ACO's previous agreement period and the first performance year of the ACO's new agreement period).

CMS should align this policy with the policy currently in place for low-performing Medicare Advantage (MA) plans. Under those regulations, CMS may terminate an MA contract that has failed to achieve at least three stars for three *consecutive* contract years. We recommend that CMS use the same three-consecutive-year standard for ACOs instead of the currently proposed standard.

Revisions to the Definition of Primary Care Services Used in Medicare Shared Savings Program (MSSP) Beneficiary Assignment.

CMS proposes revising the definition of primary care services in the MSSP regulations to include the following additions: (1) Online digital evaluation and management CPT codes 99421, 99422, and 99423; (2) assessment of and care planning for patients with cognitive impairment CPT code 99483; (3) chronic care management CPT code 99491; (4) non-complex chronic care management HCPCS code G2058 and its proposed replacement CPT code, if finalized through the CY 2021 PFS rulemaking; (5) principal care management HCPCS codes G2064 and G2065; and (6) psychiatric collaborative care model HCPCS code GCOL1, if finalized through the CY 2021 PFS rulemaking. CMS also seeks comments on permanently including HCPCS codes G2010 (remote evaluation of patient video/images) and G2012 (virtual check-ins) in the definition of primary care services used in beneficiary assignment.

CMS further proposes to modify the definition of primary care services for purposes of beneficiary assignment in the MSSP regulations. This modification would exclude advance care planning CPT code 99497 and the add-on code 99498, when billed in an inpatient care setting, from use in determining beneficiary assignment for the performance year starting on January 1, 2021 and subsequent performance years.

Additionally, CMS seeks comment on any other existing or proposed HCPCS or CPT codes that should be considered for addition to the definition of primary care services for the purpose of beneficiary assignment in future rulemaking.

We generally support the proposed modifications to the definition of primary care used for purposes of beneficiary assignment. But we also believe that the long-term effects of COVID-19 on care patterns and the use of technology are not well understood at this time. We therefore strongly encourage CMS and the Innovation Center to form a working group to study the impacts of telehealth service utilization on Advanced APM entities. The working group should continue to develop and put forward recommendations for modifying services that are used for beneficiary assignment purposes.

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We appreciate the opportunity to provide comments on the Advanced Alternative Payment Model Provisions in the Medicare Physician Fee Schedule Proposed Rule. .

Sincerely,

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