September 13, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: (CMS-1751-P) Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements.

Dear Administrator Brooks-LaSure:

The National Association of ACOs (NAACOS) appreciates the opportunity to submit comments in response to the proposed rule, Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements, as published in the Federal Register on July 23, 2021. NAACOS and our members are deeply committed to advancing value-based care, and this notable annual regulation plays an important role in shaping ACOs and the broader shift to value-based payment.

NAACOS represents more than 370 ACOs participating in a variety of value-based payment and delivery models in Medicare, Medicaid, and commercial insurers. Serving more than 12 million beneficiaries, our ACOs participate in models such as the Medicare Shared Savings Program (MSSP), the Next Generation Model, the Direct Contracting Model, and other Alternative Payment Models (APMs). NAACOS is a member-led and member-owned nonprofit organization that works to improve quality of care, health outcomes and healthcare cost efficiency.

We are pleased to provide detailed comments on many aspects of the proposed 2022 Medicare Physician Fee Schedule (MPFS) rule, which follow our summary of key recommendations below.

Summary of Key Recommendations

In response to MSSP proposals, NAACOS urges CMS to:

- Work with ACOs and the electronic health record (EHR) vendor community to find solutions to data aggregation problems, and until these solutions are widely available, electronic clinical quality measures (eCQMs) should not be mandated for ACOs. Aggregating eCQM data at the ACO level is not appropriate and, in some cases, not technically feasible at this time.
- Abandon the strategy of aligning ACO quality with the Merit-Based Incentive Payment System (MIPS) quality assessments.
- Revise the new MSSP quality performance standard. It is inappropriate to compare ACO quality performance to MIPS quality performance.
- Remove the all-payor requirement for ACOs reporting eCQMs and instead urge Centers for Medicare & Medicaid Services (CMS) to require reporting on a sample of ACO assigned patients meeting the denominator criteria.
- Identify ways to evaluate quality within APMs in a more strategic manner.
- Reinstate the previous policy to provide a pay-for-reporting year for measures that are new and/or undergo significant changes mid-year.
- Improve education and guidance provided to ACOs to support their successful transition to eCQM/MIPS CQM reporting and the new APM Performance Pathway (APP) reporting and assessments that have been created to evaluate their quality performance in the MSSP.
- Correct ongoing ACO benchmarking flaws including the "rural glitch" by removing ACO assigned beneficiaries from the regional portion of benchmarks.
- Align the use of a risk adjustment cap for the ACO and its region.
- Finalize the proposal to cut in half ACO required repayment mechanism amounts.
- Reduce burden for ACOs by removing the beneficiary notification requirement altogether.
- Absent a full repeal of the beneficiary notification requirement, finalize the proposal to amend the requirement such that ACOs that have selected prospective assignment do not have to send notification to beneficiaries that are not prospectively assigned to them.
- Finalize the proposals to streamline and simplify the MSSP application process.
- Move the deadline for ACOs to add participants until later in the year.
- Grant ACOs access to view the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) from the ACO Management System (ACO-MS).

In response to Quality Payment Program (QPP) and Medicare PFS payment policies, NAACOS urges CMS to:

- Modify policies for Advanced APM incentives to pay bonuses to APM Entities, such as ACOs
- Finalize proposed payment increases for care management services and implement CPT codes instead of temporary G-codes
- Continue to improve billing and payment for Evaluation and Management (E/M) services and finalize policies such as clarifications for billing split/shared visits and critical care services
- Reduce the data completeness level to no more than 40 percent with a gradual increase to a maximum of 50 percent for those reporting eCQMs or MIPS CQMs
- 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. This includes expanding waivers beyond the patient's site of care and geographic location.
- Refrain from putting a specific date by which CMS plans to move to full digital quality measurement for value-based purchasing programs.

Detailed NAACOS Comments

MEDICARE SHARED SAVINGS PROGRAM

ACO APP Quality Requirements

Proposals: In the final 2021 MPFS rule, CMS made sweeping changes to the way ACOs must report quality and how ACOs are evaluated on quality in the MSSP by aligning quality requirements with MIPS requirements, including a mandate that ACOs report using eCQMs/MIPS CQMs starting in 2022. In this proposed rule, CMS proposes to phase in the eCQM requirements for ACOs by continuing use of the Web Interface (WI) through 2023 and mandating all ACOs to fully report eCQMs or MIPS CQMs beginning in 2024. CMS would require ACOs using the WI in 2023 to also report at least one eCQM. CMS is also seeking feedback on whether this proposal allows sufficient lead time to provide ACOs in preparing for the full transition to mandatory eCQM/MIPS CQM reporting. CMS proposes to increase the quality data completeness standard from 70 percent to 80 percent beginning in 2023, which if finalized would apply to ACO quality reporting as well as MIPS more broadly. Finally, CMS proposes to maintain the 30th percentile quality performance standard for MSSP in 2021, 2022 and 2023 and proposes to increase the threshold to the 40th percentile beginning in 2024. CMS proposes an alternate performance standard for ACOs that elect to report eCQMs in 2022 and 2023 as an incentive for ACOs to report eCQMs.

Key Comments:

- Aggregating eCQM data at the ACO level is not appropriate and, in some cases, not technically feasible at this time. CMS should work with ACOs and the EHR vendor community to find solutions to these data aggregation problems, and until these solutions are widely available, eCQMs should not be mandated for ACOs.
- NAACOS urges CMS to abandon the broader strategy of aligning ACO quality with MIPS quality assessments.
- NAACOS continues to have concerns regarding the measure set selected for the APP eCQM/MIPS CQM measures.

Detailed Comments: NAACOS applauds CMS for being responsive to ACO and other stakeholder concernsi regarding the abrupt move to eCQM reporting at the ACO level. NAACOS supports exploring ways to improve data collection and reduce burdens, such as through the use of more digital quality measurement. Doing so will reduce the need for manual abstraction and there is potential to reduce the burden associated with quality reporting by moving to eCQMs. However, the current state of the industry is not ready to support such a change. CMS must avoid making eCQMs mandatory until standard data fields exist across EHRs and true interoperability is achieved. Further, altering EHRs, workflows, and making investments in vendor support to transition to eCQM reporting will be necessary whether the ACO is required to report one eCQM or three eCQMs, therefore we oppose the approach detailed in this regulation. Instead, CMS should make the use of eCQMs optional until standard data fields exist across EHRs and true interoperability is achieved. As ACOs and EHR vendors continue to prepare for this transition, we urge CMS to provide ACOs with at a minimum one additional year beyond what is proposed for a full transition to mandated eCQM reporting, permitting use of the Web Interface reporting mechanism through 2025, and removing the requirement to report one eCQM prior to full implementation. In a recent survey fielded by NAACOS where a quarter of all MSSP ACOs responded, 99 percent of ACO respondents report their ACO is concerned with the requirement to implement eCQMs or MIPS CQMs in 2022. Nearly 75 percent specifically noted they are “extremely concerned” or “very concerned” emphasizing the need to delay the move to eCQM reporting by ACOs.

Moreover, we urge CMS to abandon the broader strategy of aligning ACO quality with MIPS quality assessments. Tying the premier APM, the MSSP, to a fee-for-service (FFS)-focused program is a step in the wrong direction. Instead, we call on CMS to develop a more harmonized and innovative quality plan for APMs and those involved in population health efforts particularly. The MIPS program is designed to evaluate individual clinicians and groups, practicing in a FFS environment, while ACOs are focused on population health and are held accountable for quality and cost for the patients they serve. While CMS has a statutory requirement to increase the quality standard for ACOs over time, we do not believe marrying the ACO quality assessments with a FFS-focused quality assessment structure meets the intent of that statutory requirement. Over 40% of MSSP ACOs are participating in Advanced APMs, not MIPS and that number will grow over time, therefore tying ACO quality reporting to MIPS is not appropriate.

Instead, CMS should be focused on how to evolve quality measurement in the value-based environment in a more strategic manner. Currently, the Innovation Center applies a different set of quality measures and standards for each APM, and the MSSP has a different set of quality standards which are now being tied to MIPS assessments. This fragmented strategy makes participation in APMs challenging and does not advance the quality improvement and evaluation goals we would like to see implemented in value-based care settings. CMS should thoughtfully coordinate and innovate ways of evaluating APM quality, including for the MSSP. While NAACOS believes one piece of that innovation should be focused on the transition to more digital quality measurement, we note this should not be the sole focus of these efforts. We provide more detailed comments on this issue in our letter below in response to the digital health Request for Information (RFI) contained in this regulation.

Finally, we continue to have concerns regarding the measure set selected for the APP eCQM/MIPS CQM measures. We reiterate our previous commentsii that these measures are narrowly focused and result in greater emphasis being placed on patient satisfaction and a narrowly focused clinical measure set. The MSSP started with 31 quality measures used in assessing ACOs, which was onerous and included many low value measures. CMS later reduced the measure set to 24 and later to 10 measures at the urging of NAACOS. Now the agency has reduced the measure set to three clinical quality measures. Also under the new APP rules, CMS will suppress some of those measures when there are issues with a benchmark, etc., thereby further reducing the measure set. To evaluate the totality of an ACO's quality performance on only one measure is inappropriate and unfair. Additionally, CMS did not utilize the Measure Applications Partnership (MAP) to obtain stakeholder feedback and input on the most appropriate measure set for use in the APP, and we call on CMS to look at ways to evaluate quality within APMs in a more strategic manner. Coupled with the new APP policy to suppress measures that undergo significant changes and/or benchmark issues during the performance year instead of reverting a measure to pay-for-reporting, this could result in ACOs entire performance hinging on two or three total measures. This is not appropriate for a program such as the MSSP where ACOs are financially accountable for total cost of care losses for a large population, which can mean paying millions back to CMS should spending be higher than benchmarks. We urge CMS to instead revert to the prior policy to make measures pay-for-reporting when measure changes occur mid-year and/or when there are issues with a benchmark for a measure in the ACO measure set. Finally, we also urge CMS to consider changes to measure criteria to ensure appropriate exclusions for frailty are incorporated regardless of reporting method.

Obstacles to Moving to eCQM Reporting for ACOs

Proposals: There are many technical and operational challenges to requiring ACO level eCQM reporting. While eCQMs are currently reported in MIPS, individual clinicians and group practices in MIPS are not required to aggregate the data in the manner an ACO is required to do so when reporting one, aggregate Quality Reporting Document Architecture (QRDA) III file to CMS.
Key Comments:

- According to a NAACOS survey of ACOs, nearly half of ACOs' participating practices use 11 or more EHRs, and the biggest barrier cited for movement to eCQM reporting was the lack of EHR standardization.
- Data completeness standards will be difficult if not impossible for some ACOs to operationalize as CMS has clarified that ACOs will be responsible for de-duplicating patient data when submitting aggregate QRDA III files to CMS.

Detailed Comments: There are many obstacles to moving ACOs to eCQM reporting that arise from ACO participants having the freedom to use disparate EHRs. Contrary to CMS's statements in this regulation, using 2015 Certified Electronic Health Records Technology (CEHRT) does not solve these data aggregation issues. Many EHR products that are CEHRT may not have certain features of technology 'turned on' or available to a practice or clinician to use without paying large fees to utilize such features. Additionally, different EHR products approach data collection in different ways, resulting in poor measurement of quality actions across practices and across ACOs. For example, test results can often be placed in different data collection fields. Therefore, more focus is placed on where the care is documented and collected in a specific EHR or EHR product versus the actual quality of care performed. This can result when tests have been completed at another location, such as a mammogram, or with lab results such as hemoglobin A1C, which does not get incorporated electronically into the medical record. Therefore, each EHR vendor may handle documentation of these results differently.

These problems are exacerbated when trying to report measures at the ACO level; according to a NAACOS survey of ACOs, nearly half of ACOs' participating practices use 11 or more EHRs and the biggest barrier cited for movement to eCQM reporting was the lack of EHR standardization. Further, nearly 70 percent of survey respondents reported that their ACO does not have software in place to assist with integrating and extracting quality data from their participating Tax Identification Numbers' (TINs) EHRs.

Additionally, data completeness standards will be difficult if not impossible for some ACOs to operationalize as CMS has clarified that ACOs will be responsible for de-duplicating patient data when submitting aggregate QRDA III files to CMS. It is still not clear that there is a way to achieve this goal from a technological standpoint. QRDA III files are aggregate files with no patient identifier. ACOs only have access to ACO beneficiary data; even if QRDA III files contained patient identifiers, there is no way an ACO can serve as the data matching source of truth for all patients/all payors from disparate EHR systems. Not being able to de-duplicate patients is particularly problematic in this context because specialists are being held accountable for primary care measures under the current structure, as described in further detail below. These specialists are not clinically responsible for coordinating the entirety of the patient's care and therefore often do not capture all the data needed for the ACO eCQM measures. As an example, a dermatologist should not be expected to track a patient's Hemoglobin A1C levels. This inevitably can underreport the quality of care provided by an ACO and therefore also be problematic when establishing benchmarks.

This is particularly problematic because ACOs that must report on a predetermined measure list will be compared to MIPS clinicians who are able to cherry pick measures to report. For this reason, NAACOS continues to oppose the benchmarking approach finalized in the APP, as it is unfair and inaccurate to compare quality scores for ACOs versus those reporting individual measures in MIPS. Finally, we caution CMS that ACOs are considering excluding specialists from their ACOs due to the impact on quality scores described above, should CMS move forward with this approach. Some specialists are also choosing to leave ACOs to avoid being measured on work that is clinically irrelevant to their specialty and to avoid new administrative and reporting burdens for duplicative or inappropriate quality reporting. This would further fragment care and is not aligned with the goals of the ACO model. We urge CMS to resolve this issue as soon as possible to ensure ACOs can continue to include specialists in their efforts.

This emphasis on how data is collected in the EHR rather than the quality provided to the patient has diminished buy-in from clinicians who are increasingly feeling that quality measurement is more about the 'check the box' action than true quality improvement efforts. CMS should devote equal attention and focus on policies to drive quality improvement. In addition, CMS must acknowledge the costs and burdens being placed on ACOs under these policies. For some ACOs these costs can be hundreds of thousands of dollars and significant staff time to operationalize these changes. These costs and burdens will disincentivize participation in ACOs. CMS's goal should be to increase incentives for provider participation in APMs, including MSSP ACOs, and therefore these costs and burdens must be considered.

ACO Quality Performance Standard

Proposals: In the final 2021 MPFS rule, CMS made significant changes to the MSSP quality performance standard, which is used in determining whether an ACO is eligible for shared savings, and if the ACO owes losses, the amount of losses to be paid to CMS. Notably, starting with performance year (PY) 2021 to determine whether ACOs have met the MSSP quality performance standard, CMS compares ACO quality performance to all MIPS final quality performance category scores. Previously, ACOs beyond the first performance year of their first agreement period were required to meet a minimum attainment standard which was set at the 30th percentile benchmark for pay-for-performance measures on at least one measure, in each of the four domains CMS established within the WI measure set. The comparison group was WI reporters, the vast majority of which were ACOs. Finally, CMS used an approach that adjusted savings rates based on an ACOs actual quality score.

Key Comments:

- NAACOS calls on CMS to revise the new MSSP quality performance standard. It is inappropriate to compare ACO quality performance to MIPS quality performance and CMS should revert to the previous methods for evaluating the MSSP quality performance standard/minimum attainment.
- We also stress the importance of providing ACOs with their performance benchmarks prior to the beginning of the performance year.

Detailed Comments: NAACOS reiterates that we believe it is inappropriate to compare ACO quality performance to MIPS quality performance category scores. Instead, CMS should revert to the previous methods for evaluating the MSSP quality performance standard (previously the minimum attainment standard). While individual clinicians and groups in MIPS can select to report the quality measures they expect to perform highest on, ACOs must report a pre-selected measure set. Therefore, tying the MSSP ACO quality performance standard to all MIPS final quality performance category scores is inappropriate and an unfair comparison. CMS's own estimates conclude that 20 percent of ACOs would fail under this approach; this would have a devastating effect on the program's participation and would unfairly categorize nearly a quarter of ACOs as having poor quality, when the program has clearly demonstrated high quality performance. Further, we urge CMS to consider the value of the performance criteria that has been established if the 40th percentile score is equivalent to 95.7, a near perfect score. This results in a system that is only punitive. To identify ACOs with a score of 94 out of 100 as having poor quality is unfair and inappropriate, particularly when CMS is already making unfair comparisons in this calculation by comparing ACO scores to all MIPS quality performance category scores. This approach does not provide ACOs with credit for their ongoing quality improvement work. It is critical that CMS return to a quality measurement approach that adjusts shared savings based on an ACO's quality score and using a minimum attainment threshold that is making fair quality comparisons and represents clinically meaningful differences in quality performance.

We again urge CMS to consider a different strategy for assessing APM quality attainment and improvement assessments that is more APM focused. In the absence of these changes, at a minimum we

urge CMS to reconsider increasing the performance threshold the same year the WI is retired. Therefore, if CMS does not reconsider a broader strategy to separate the MSSP quality assessments from MIPS quality assessments and revert to the previous quality performance standard methodology approach as we recommend, we urge the agency to maintain the 30th percentile performance standard through 2025.

We also stress the importance of providing ACOs with their performance benchmarks prior to the beginning of the performance year. ACOs engage their clinicians in performance improvement activities throughout the year and need benchmarks to be able to gauge performance and deploy improvement strategies. We believe ACOs should be compared only to other ACO for performance, and the benchmarks must be provided prior to the beginning of the performance period. As CMS considers avoidance of 2020 performance in establishing benchmarks due to COVID-19, we urge CMS to use 2019 data so that ACOs can be provided with a benchmark prior to the beginning of the performance year. NAACOS also has questions regarding the estimates provided on page 39274 of the proposed rule for what the performance standard would be looking at 2018 and 2019 MIPS data to establish the 30th and 40th percentile scores for all MIPS quality performance category scores. CMS states that for 2018 data, the 30th percentile score would be equivalent to 83.9 and the 40th percentile 93.3. For 2019 data, the 30th percentile was equivalent to 87.9 and the 40th percentile 95.7. We question the validity of these calculations. NAACOS urges CMS to provide more transparency around how this standard is being calculated, and we call on CMS to provide more information on this calculation, using specific numeric examples. We also call on CMS to provide additional information regarding how 'entities eligible for facility-based scoring' will be removed from such calculations for ACOs, and whether ACOs will be accountable for quality reporting under eCQM reporting for facilities such as Federally Qualified Health Centers (FQHCs), and/or other entities eligible for facility-based scoring, when reporting measures to CMS.

Data Aggregation Issues: Request for Feedback

Proposals: CMS seeks comment on policy changes that may alleviate concerns with ACO data aggregation issues related to the move to eCQM/MIPS CQM reporting. Specifically, CMS seeks comment on allowing ACO providers/suppliers to submit eCQMs/MIPS CQM measures to CMS at the ACO participant TIN level, instead of requiring ACOs to aggregate this data and submit one numerator/denominator to CMS. CMS could then calculate an ACO-level numerator for each measure (sum of performance met across TINs within the ACO) and an ACO-level denominator (sum of the met and performance not met across TINs within the ACO), then divide the two—numerator/denominator x 100—to obtain the ACO-level performance rate.

Key Comments:

- Data completeness standards will be difficult if not impossible for some ACOs to operationalize, as CMS has clarified that ACOs will be responsible for de-duplicating patient data when submitting aggregate QRDA III files to CMS.

Detailed Comments: CMS states that an ACO that submits eCQM quality data to CMS must de-duplicate the patient level measures data across its ACO providers/suppliers to ensure that the aggregated QRDA III file that is submitted to CMS incorporates only quality data that meets the intent of the measure. As stated earlier, it is still unclear to ACOs how they will technically be able to achieve this goal. QRDA III files are aggregate files with no patient identifier. ACOs only have access to ACO beneficiary data; therefore, even if QRDA III files contained patient identifiers, there is no way an ACO can serve as the data matching source of truth for all patients/all payers from disparate EHR systems. NAACOS questions how CMS would have the ability to de-duplicate patients if the agency allowed TIN level reporting of eCQMs to then aggregate to create an ACO performance rate by CMS. NAACOS feels aggregation at the ACO level is

simply not appropriate at this time. CMS should work with ACOs and the EHR vendor community to find solutions to these problems, and until these solutions are widely available eCQMs should not be mandated for ACOs. Some ACOs may be able to report eCQMs with ease, as an example, a single-TIN ACO on one EHR. However, many ACOs are comprised of both independent and employed providers across many TINs, each with their own EHR, and in some cases their own instances of the same EHR. For these ACOs it will be impossible to de-duplicate patients, and therefore eCQM reporting must remain optional until technical solutions to this problem exist. Otherwise, if CMS moves forward with this approach, quality assessments will be inaccurate, and therefore it would be inappropriate to measure performance and hold ACOs accountable for their performance on such measures.

All-Payor and Denominator Size Issues: Request for Feedback

Proposals: CMS notes that ACOs have raised concerns with the move to eCQM/MIPS CQM reporting and the issues that arise with requiring reporting on all-payor data. As such, CMS seeks comment on alternatives to this all-payor requirement in eCQM reporting applied to ACOs. Specifically, CMS seeks feedback on the following questions: Should ACOs report on a small sample size similar to the sample size for the CMS WI? Should CMS revise the beneficiary sample to include all ACO assigned beneficiaries that meet the denominator for a given measure? Should CMS provide ACOs with a bigger sample size that is larger than the size that has historically been used for CMS WI but smaller than all of the assigned beneficiaries that meet the denominator for a given measure, regardless of payor? Should CMS develop other ACO-level eCQM/MIPS CQM measure sampling specifications?

Key Comments:

- NAACOS urges CMS to remove the all-payor requirement for ACOs reporting eCQMs and instead urges CMS to require reporting on a sample of ACO assigned patients meeting the denominator criteria. We feel this is a more reasonable expansion of the criteria and more aligned with the goals of the MSSP.

Detailed Comments: NAACOS thanks CMS for its recognition of the challenges that exist when applying all-payor data to ACO reporting of eCQMs. Should CMS move forward with the current approach of applying MIPS quality requirements to ACOs, we urge the agency to revise requirements to specify that ACOs must report on a sample of ACO assigned patients meeting the denominator criteria. We feel this is a more reasonable expansion of the criteria and more aligned with the goals of the MSSP. We continue to believe that a sampling methodology focused on ACO assigned patients is more appropriate for assessing ACO quality and will provide more accurate evaluations of quality. Importantly, we believe these criteria will also not allow CMS to evaluate the impact ACOs are having on quality versus its FFS peers, which should remain an important goal for CMS.

The current data completeness criteria that exist for eCQM/MIPS CQMs are not appropriate when applied at the ACO level. The current approach, which requires ACOs reporting eCQMs/MIPS CQMs to report on all patients meeting the measure denominator criteria, regardless of payor, for at least 70 percent (80 percent as proposed for 2023) of patients would dramatically increase the number of patients an ACO is required to report on. While ACOs do focus on improving the health of all patients they serve, it is not appropriate to hold ACOs financially accountable for non-assigned patients. ACOs who do not meet quality standards are ineligible to earn any savings they generate, and if accountable for shared losses, they could owe the maximum shared loss rates for missing quality targets. ACOs should only be held accountable for their assigned patients. We caution that ACOs and vendors will need time to make this technically feasible, as currently it can be difficult if not impossible for some ACOs to be able to extract patient-level data for the eCQM for a list of assigned ACO patients, as it stands today. Again, CMS

must also recognize the additional costs ACOs will face to make such technology upgrades. This further emphasizes the need for CMS to make eCQM reporting optional until such technical issues are resolved.

In addition, because the number of patients to whom the measures would apply has increased exponentially and many of the measures are broadly specified, patients who receive care from a specialist participating with an ACO will be attributed as eligible for a measure denominator for a clinical service intervention that is outside of the typical scope and practice of that clinician. Certain specialists may consider it clinically inappropriate for them to take steps to meet the primary care quality measure if the measure and its related care are outside of their professional focus. For example, if an ACO-assigned beneficiary has an annual skin exam and a diagnosis of diabetes is also captured in the medical record, then MIPS#001, Diabetes: Hemoglobin A1c (HbA1c) Poor Control will be attributed to the dermatologist, and the ACO will be required to include this visit in the measure denominator regardless of whether the HbA1c control is outside of the focus of the visit or purview of the dermatologist. This creates the potential that performance will not be met and ACO quality scores would be negatively impacted. Requiring specialists to collect additional data and/or provide additional services outside of their usual work could also serve as a distraction and negatively impact care delivery. Further, in some cases, such as the Depression Screening and Follow Up measure, a specialist would be expected to provide a service which it would not be reimbursed for given the billing requirements associated with the service.

This concern increases significantly with the all-payer requirement since it will be extremely challenging, if not impossible due to issues regarding access to data and potential violations of the Stark or HIPAA laws, for ACOs to track patients and provide interventions when they have no direct relationship to the ACO. These concerns are leading some ACOs to consider dropping certain TINs from their ACO, while at the same time certain TINs may choose to leave the ACO to avoid burdensome new quality reporting requirements that they feel are not applicable to their practice. Either way, this unintended consequence of reducing the breadth of providers engaged in a total cost of care model is troubling.

Due to the issues described above, we continue to believe that a sampling methodology focused on ACO assigned patients is more appropriate for assessing ACO quality and will provide more accurate evaluations of quality. This approach is more accurate, more relevant and a fairer comparison of quality for ACOs. In the NAACOS survey of members discussed above, data access concerns were one of the top three barriers identified by survey respondents; this concern is directly relevant to the expansion to all-payer data. The WI includes a sample of 248 assigned ACO patients. Additionally, there is precedent for using a sampling method in other programs such as the Medicare Advantage (MA) program, which assesses quality based on the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) methodology for hybrid measures using a sample of 411 patients. This is the maximum sample size and is used for MA plans covering thousands or tens of thousands of patients in many cases. This approach is also taken with many commercial plans. Further, in a program where ACOs are held financially accountable for all costs and quality of care provided to patients, it is inappropriate and unreasonable to tie quality requirements to non-ACO and non-Medicare patients.

Finally, should CMS instead move forward with an all-payor requirement, we request CMS lower the data completeness level to no more than 40 percent with a gradual increase to a maximum of 50 percent for those reporting eCQMs or MIPS CQMs. Another alternative would be for CMS to 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 approach would ensure that ACOs perform well on a substantial set of measures to earn savings, but it does not punish ACOs that miss the mark on a measure that is either not as relevant to their patient populations or has a very narrow range of performance rates.

Specialists and Quality Measurement in ACOs: Request for Feedback

Proposals: CMS seeks comments related to how specialists should be evaluated on quality in the context of ACOs using digital quality measurement. CMS seeks feedback on the following questions: Should CMS allow ACO participant TINs to report either the eCQM/MIPS CQM measures in the APP measure set at the TIN level or the applicable MIPS Value Pathways (MVP)? How could APP and MIPS Value Pathway data reported at the ACO participant TIN level be aggregated in order to assess ACO quality performance? What specialty measures in the current eCQM or MIPS CQM measure set should be considered for inclusion in the MSSP quality measure set in future performance years? Alternatively, how could the existing APP measure set be used or modified to reinforce the role of specialists in ACO population health strategies?

Key Comments:

- It is important that CMS does not introduce complicated MVP policies to ACO quality reporting requirements.

Detailed Comments: Engaging specialists and all clinicians in an ACO is critical to achieving the population health goals of the MSSP. When considering adding specialty specific measures to the ACO quality measure set, CMS must first solve the problem of attribution that currently exists in the eCQM/MIPS CQM specifications when applied at the ACO level. As an example, using the eCQM requirements applied at the ACO level for the current depression screening measure, the ACO must report on all visits to any participant TIN clinicians who see patients with a diagnosis meeting the measure criteria. This would include both a primary care clinician, for whom the measure would be appropriate, and potentially a urologist for whom it would not be considered appropriate to provide a depression screening and provide necessary follow-up during the patient's urology appointment. This example emphasizes the flawed nature of trying to apply the MIPS requirements to ACOs. There are fundamental differences when applying quality assessments for ACOs at the population health level, and as such, CMS should deploy a different strategy for evaluating ACO quality.

CMS also discusses, but does not formally propose, to apply MVP policies to ACOs as a way to incorporate more specialty specific measures. It is important that CMS does not introduce complicated MVP policies to ACO quality reporting requirements. The complexity introduced by the concepts of allowing subgroup participation would introduce even more uncertainty and complexity to the flawed APP design that CMS has chosen to implement. ACOs are currently evaluated on administrative claims measures that assess patient outcomes across the continuum of care. ACOs are also responsible for total cost of caring for the entire patient population they serve; therefore engaging the broad range of specialists in the ACO is critical and already captured in these assessments. This reiterates the need for CMS to begin addressing quality measurement in APMs and population health focused payment models in a more strategic and targeted manner. Should CMS consider specialty specific quality measures in the context of ACOs, the agency must limit evaluation to those specialties that are eligible to draw attribution for the ACO. That said, we ultimately recommend that CMS not add required specialty focused quality measures to the MSSP because these measures may not be appropriate for many ACOs or for an ACO model that has an underpinning of primary care.

Health Equity and the eCQM Requirement for ACOs: Request for Feedback

Proposals: CMS notes the agency believes the move to eCQMs and measuring quality for all payors will assist in improving health equity, and it seeks comment on other ways to improve health equity in the MSSP, including the following questions: How can ACOs utilize their resources to ensure that patients, regardless of racial/ethnic group, geographic location and/or income status, have access to equal care;

and how ACOs can improve the quality of care provided to certain communities, while addressing the disparities that currently exist in health care? How can CMS encourage health care providers serving vulnerable populations to participate in ACOs and other value-based care initiatives? Should adjustments be made to quality measure benchmarks to take into account ACOs serving vulnerable populations?

Key Comments:

- CMS must avoid adjusting quality benchmarks for race and ethnicity.

Detailed Comments: We thank CMS for soliciting comments on this important topic. As CMS has currently applied the digital quality measurement (eCQM/MIPS CQMs) standards to ACOs, CMS is not advancing health equity goals but rather exacerbating these problems. The current eCQM/MIPS CQM standards applied to ACOs will unfairly and disproportionately penalize ACOs who serve a large proportion of vulnerable populations. ACOs who are comprised of many FQHCs, as an example, could see lower quality scores due to the nature of the patient population they serve under these digital health standards, as compared to using the sampling approach that CMS currently applies for the WI and for MA plans. NAACOS has raised this issue with the new requirements in the APP for ACOs, and we reiterate our request that CMS move away from this approach.

Improving health equity is critical to delivering high quality care in a cost-effective manner, as some research shows that social drivers of health contribute more significantly to health outcomes than medical care. Innovative payment and care delivery models that rely on data provide an opportunity to better understand and highlight existing disparities and the tools to tailor interventions based on individual need. For example, ACOs assume accountability for a population's cost and quality of care, and many are beginning to address patients' social needs such as housing, transportation, and food insecurity as a way to improve health outcomes.

One important way to support ACOs in addressing health equity is through quality measurement at the population health or ACO level. There are many quality measures that CMS currently considers to be "topped out," meaning performance is high among most reporting the measures; however these measures may show additional room for improvement when stratified by social risk factors such as race/ethnicity or zip code. Stratifying quality measures by social risk factors may allow ACOs to target tailored interventions designed to have the most meaningful impact on underserved populations. In this way, ACOs can address health inequities existing within their patient populations. These efforts to address health inequities through quality measurement must be coupled with other efforts to support ACOs in addressing health equity. Equity initiatives require significant upfront investment to be effective, and therefore ACOs require additional flexibility and resources to be able to address these concerns with their patient populations.

NAACOS recently authored a white paper that discusses seven policy changes CMS should consider, which could help to advance the efforts of quality improvement in relation to improving equity in health outcomes across ACOs. These policy changes must be implemented in a step-wise manner, and each recommendation is designed to build off of the learnings of each change. Importantly, it must be emphasized that relying on good data to address health equity is critically important to the success of these efforts. It is critical to note that we cannot embark on these changes without also giving clinicians and ACOs the tools and resources they need to implement and deploy interventions to reduce these inequities and to improve patient care for underserved populations. There must also be a recognition that health equity solutions will be localized and therefore will need to look different in different locations, markets, and populations. Finally, as these policy options are considered it is important to recognize the additional burden that may be placed on clinicians. Therefore, it will be critical to find ways to minimize this burden that could come in the form of additional data collection requirements and

potential costs to alter EHRs to collect and report data. NAACOS is committed to advancing the value-based care movement and our members want to see an effective, coordinated, patient-centric healthcare system that focuses on keeping all individuals healthy. Implementing these policy changes can provide an important opportunity to reduce health inequities and transition our health system to a culture of value. NAACOS urges CMS to consider:

- Collecting race/ethnicity data in a more standardized way, with incentives for ACOs who are able to be early adopters of these efforts
- Updating patient survey data to incorporate health equity
- Providing incentives to ACOs who attest to using a SDOH screening tool
- Stratifying a subset of quality measures by race/ethnicity
- Providing incentives to ACOs for improving quality scores for subpopulations identified as having lower performance based on race and ethnicity categorizations. This could be done through bonus or improvement points added to an ACO's final quality score.
- Developing new quality measures to address health equity
- Avoiding adjustments to quality benchmarks for race/ethnicity

We stress that CMS must avoid making adjustment to quality benchmarks for race and ethnicity. Doing so is endorsing and accepting that for an underserved population, it is acceptable to have lower quality or poor outcomes. Instead, CMS should implement the policies described above to more appropriately address this issue.

Retaining Pay-for-Reporting When Measures Are Newly Introduced or Modified

Proposals: In the final 2021 MPFS rule, CMS removed the pay-for-reporting policy previously applied when measures were newly introduced and/or when a measure underwent significant changes mid-year or had no benchmark. Rather, effective in 2021 and subsequent years, CMS will suppress these measures from the APP measure set instead of giving full credit (pay-for-reporting).

Key Comments:

- CMS should reinstate the previous policy to provide a pay-for-reporting year for measures that are new and/or undergo significant changes mid-year.

Detailed Comments: We believe that CMS should reverse removing the pay-for-reporting year for measures that are new or with significant changes. Otherwise, ACOs may be held accountable for less than three clinical quality measures as the new policy suppresses such measures, placing more emphasis on a very minimal number of measures. Providing the pay-for-reporting year is critical to an ACO's success as it allows an ACO to evaluate its current workflows, data capture processes, and other operational strategies to see where changes are needed and what areas require focus when a measure undergoes significant changes. Further, providing a newly introduced measure or a measure undergoing significant changes 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 assessing not only true quality but also how the quality data are captured.

Outstanding APP Implementation Questions for ACOs

Proposals: While CMS has published one guidance document for ACOs on the APP requirements, this guide does not answer the many technical and operational questions ACOs have regarding the move to eCQM reporting as well as questions regarding how APP scores are calculated for ACOs.

Key Comments:

- CMS must improve education and guidance provided to ACOs to support their successful transition to eCQM/MIPS CQM reporting and the new APP reporting and assessments that have been created to evaluate their quality performance in the MSSP.

Detailed Comments: NAACOS has an outstanding list of technical questions that we urge CMS to provide answers to facilitate ACOs beginning the transition and preparation necessary to move to eCQM reporting. It is critical that CMS invest in the design of resources tailored to ACOs specifically and increase education among QPP staff so that ACOs are obtaining accurate information from Help Desk and other support staff to obtain the answers they desperately need to be successful under the new requirements. Not all ACOs are organized and structured in the same manner, and therefore addressing their educational needs often requires a very tailored approach. This is critical to ACOs' success, and we urge CMS to work with ACOs and stakeholders to better understand the needs of ACOs in terms of education and outreach. CMS must provide additional guidance, tailored to ACOs. This guidance must be timely, accurate and made publicly available in writing to all ACOs. The following list of questions has been posed to CMS many times since the final 2021 MPFS rule was released. This list includes outstanding issues that CMS must clarify in public guidance to ACOs as soon as possible to allow ACOs to begin to transition to eCQM/MIPS CQM reporting.

- CMS states if an ACO decides to report both the 10 CMS WI measures and the three eCQM/MIPS CQM measures, it will receive the higher of the two quality scores for purposes of the MIPS quality performance category. CMS must clarify whether this policy applies for PY 2021, as this is not expressly stated in the rule.
- Will ACOs be permitted to combine eCQM and MIPS CQMs? If so, what benchmarks will apply?
- How is the final ACO quality performance threshold calculation conducted? Please provide specific numeric examples.
- How are ACOs expected to include or exclude 'entities eligible for facility-based scoring' from quality reporting? How will CMS exclude these scores from final quality scores?
- CMS proposes a lower performance standard in 2022 and 2023 for ACOs who choose to report eCQMs, requiring an ACO to meet the 30th percentile on one of the APP measures. Please clarify if the ACO must meet the 30th percentile on one of the three eCQM/MIPS CQMs or one of the six total APP measures, including Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS and administrative claims measures.
- How are ACOs expected to de-duplicate patient data using a QRDA III file, as this is an aggregate file that does not include patient level information?
- How should an ACO handle reporting of patients who opt out of data sharing for the ACO?
- Can an ACO notify participant TINs about non-ACO patients who are in need of interventions, identified through reporting, in light of the Stark Law limitations that exist?

Using of Regional FFS Expenditures ACO Benchmarks and Fixing Risk Adjustment

CMS seeks feedback on, but doesn't formally propose changes as of yet, to the regional adjustment of MSSP benchmarks. Specifically, CMS wants feedback on how to account for the removal of ACO-assigned beneficiaries from the regional reference population, which is used to determine the regional portion of benchmarks. Including ACO-assigned beneficiaries in the regional portion of the benchmark is a flaw

often referred to as the "rural glitch" because it disproportionately harms rural ACOs, though the issue affects urban and suburban ACOs as well.

Key comments:

- CMS should take the opportunity to fix the rural glitch by making formal regulatory changes to remove ACO-assigned beneficiaries from the regional reference population, which should be implemented as soon as possible. Specifically, to do that CMS should remove ACO beneficiaries from calculation of the regional risk-adjusted PMPY.
- CMS should use a regional-only trend, which is a better reflection of a local market than a national trend or a blended national-regional trend.

Detailed Comments: NAACOS greatly appreciates CMS seeking feedback on how MSSP benchmarking methodology can be adjusted to remove ACO-assigned beneficiaries from the regional reference population. This is an issue NAACOS has raised with the agency for several years, including through commentsiii to MSSP proposed regulation changes in 2016 when CMS updated MSSP benchmarking policies and in 2018iv when the agency published MSSP changes it called "Pathways to Success." Unfortunately, our recommendations were not implemented, and a benchmarking methodology that unfairly penalizes many ACOs and undermines the intent of a regional comparison persists. We urge CMS to take the opportunity to fix this issue by making formal regulatory changes to remove ACO-assigned beneficiaries' costs from all Medicare ACO demonstrations from the regional reference population, which should be implemented as soon as possible. Specifically, to do that CMS should remove ACO beneficiaries from calculation of the regional risk-adjusted PMPY. CMS should compare ACO performance relative to FFS Medicare by defining the reference population as assignable beneficiaries without ACO-assigned beneficiaries for all ACOs in the region.

Correcting this flaw, or "rural glitch" as it is often called, is about creating a fair and accurate benchmark for ACOs. The rural glitch systematically penalizes an ACO when it reduces costs. Specifically, when an ACO lowers the total cost of care for its assigned population, it also reduces the average regional costs and diminishes the positive effect of the regional adjustment. This defeats the purpose of a benchmark that is based in part on regional expenditure data, which CMS has acknowledged is fair and necessary for a viable ACO program long-term. Further, the current methodology attempts to fix problems caused by the rural glitch by using a trend with a national-regional blend. That approach is misguided as it dampens the effect of regional trend, diminishing the incentive that ACOs have to concentrate in high-spending areas of the country and control spending at the local level. As ACOs' implement clinical transformations and practice patterns to reduce unnecessary costs, those efforts can reduce spending in their region, both for beneficiaries assigned to the ACO and those who are not assigned to the ACO. These "spillover" effects across the region lower regional spending, which makes it more difficult for the ACO to earn the shared savings necessary to keep these initiatives going.

The larger the ACO's market share the bigger effect the rural glitch has. By excluding ACO beneficiaries' costs from the regional reference population, CMS would stop comparing an ACO's performance to itself. Again, correcting this issue is a matter of fairness and accuracy. In addition to excluding all ACO-assigned beneficiaries' costs from the regional reference population, we also urge CMS to exclude beneficiaries assigned to other Medicare ACO demonstrations, including the Global and Professional Direct Contracting Model, which would allow for a cleaner comparison between ACOs and FFS.

NAACOS undertook research in 2020 in connection with the introduction of the Value in Health Care Actv (H.R. 4587), which corrects the rural glitch, among making other meaningful improvements to MSSP and Advanced APMs. That research looked at 2018 Medicare claims data and found that nearly 80 percent of MSSP ACOs would benefit from removing ACO-assigned beneficiaries' costs from the regional reference

population. However, NAACOS found no consistent pattern among those that would benefit and those that wouldn't. While CMS is considering alternative benchmarking methodologies to address ACOs' penetration in their regions, this research illustrates that correcting the rural glitch doesn't inherently harm ACOs with low market share. Instead, the benefit of removing all ACO-assigned beneficiaries' costs from the regional reference population has more correlation to an ACOs' spending relative to the rest of its region, and therefore considering alternative, potentially more complicated policies is unnecessary. While this issue is referred to as the rural glitch, the benchmarking flaw also affects many urban and suburban ACOs, but often to a lesser extent than their rural counterparts. As part of our ongoing collaboration with CMS, NAACOS is happy to share this research in greater detail with the agency.

In the proposed 2022 MPFS rule, CMS shows the range of the effect, both positive and negative, that removing all ACO-assigned beneficiaries' costs from the region would have. But CMS doesn't state how many ACOs would benefit versus be harmed. Instead, the agency asks for comments on ways to mitigate the negative effect this could have on certain ACOs, while still benefiting others. But the vast majority, nearly 80 percent, would benefit from the correction of the rural glitch without making additional, potentially more complicated policy. NAACOS believes the simplest way to address this issue would be to remove all ACO-assigned beneficiaries' costs from MSSP regional reference populations. Specifically, to do that CMS should remove ACO beneficiaries from calculation of the regional risk-adjusted PMPY.

In the past, CMS raised concerns that removing ACO-assigned beneficiaries would result in a reference population that is not large enough. This is especially true in certain high-risk beneficiary groups such as those who are dually eligible for Medicare and Medicaid or have end-stage renal disease (ESRD). However, as NAACOS has stated in past comment letters to the agency, this likely is only an issue for a minority of ACOs. If CMS needed to, it could use a number of options, including expanding the regional service area to include assignable beneficiaries in adjoining counties or increasing the number of years included in the calculation to improve the stability of the regional adjustment.

In the 2018 Pathways to Success rulemaking, CMS attempted to address the rural glitch benchmarking flaw in part by implementing a blended national-regional trend to update historical benchmarks. But that doesn't help ACOs who successfully lower the spending on their assigned populations. In fact, a blended national-regional trend often over-emphasizes the national trend component for ACOs that comprise a large market share. Relying too heavily on a national trend is especially problematic during a pandemic as it ignores important local market dynamics that differ across the country. NAACOS saw the regional spending in some markets drop by 10 percent or more in 2020 while remain relatively flat in others. ACOs in COVID hot spots will likely have higher costs than the overall nation. Therefore, using the national trend as part of the benchmarking methodology is detrimental and unfair to these ACOs as it does not reflect the pandemic's effect on costs in their regions. We request CMS modify the benchmarking methodology due to the unusual effect of the pandemic on spending. Specifically, we ask CMS to use a regional-only trend, which is a better reflection of a local market than a national trend or a blended national-regional trend.

CMS raises additional questions in the proposed rule, seeking solutions to potential policy issues around consolidation and disincentives for ACOs seeking out some patients. While there has been increased consolidation in recent years across the healthcare industry, there is not strong evidence showing ACOs are driving this, as leading researchers[vi] wrote in 2017. Many other factors[vii] are driving consolidation, such as the desire for provider systems to negotiate higher prices with payers, payment policies like site-neutral payments, and administrative complexity that causes small, independent practices to work within a larger system. While consolidation and ACO growth have been factors in our healthcare system in the past decade, correlation should not be confused with causation. Many other changes have also happened during this time to further obscure the cause.

For the latter issue, the likelihood of ACOs possibly avoiding high-risk patients if the rural glitch is corrected is quite low. There is no evidence of ACOs avoiding high-risk patients in response to the introduction of MSSP benchmarks with a regional expenditure component, so it seems equally unlikely that making the regional benchmarking formula fair for all ACOs would result in this. Further, MSSP already has safeguards in place to prevent ACOs purposefully avoiding certain populations. For example, provider choice is a hallmark of traditional Medicare in which MSSP operates, beneficiary assignment evolves over time in response to patient choice, and total cost of care for high-risk populations is risk-adjusted to appropriately modify spending compared to benchmarks. Therefore, we view the concerns discussed in the proposed rule as unfounded and much less troubling that the issue at hand, which is to fix the rural glitch. It is clear that the rural glitch causes problems for most ACOs and finally fixing it would benefit ACO formation and long-term program sustainability, bringing the benefits of ACOs to millions more patients in traditional Medicare.

We urge CMS to take the opportunity to fix this issue by making formal regulatory changes to remove all ACO-assigned beneficiaries' costs from the regional reference population, which should be implemented as soon as possible. CMS should compare ACO performance relative to FFS Medicare by defining the reference population as assignable beneficiaries without ACO-assigned beneficiaries for all ACOs in the region. We know this policy is problematic and that CMS's past efforts to correct it have fallen short. A simple, straightforward solution would benefit the vast majority of ACOs. If CMS is interested in growing ACO participation, it needs to correct this issue to incentivize more providers to form and participate in ACOs. Correcting this issue would help create more realistic benchmarks for ACOs, creating a more level playing field to attract ACOs.

Risk Adjustment

CMS seeks feedback on important aspects of the MSSP risk adjustment methodology, which takes into account changes in severity and case mix of the ACO's assigned beneficiary population when establishing the benchmark and adjusting the benchmark each performance year. Specifically, the agency seeks input on approaches to improving the risk adjustment methodology, including for ACOs with medically complex, high-cost beneficiaries. The agency also specifically seeks input on how to modify risk adjustment to balance the need for accurate and complete coding while protecting against incentivizing ACO coding intensity initiatives. CMS discusses alternate approaches to their current methodology such as increasing the cap on an ACO's risk score growth in relation to risk score growth in the ACO's regional service area.

Key comments:

- CMS should update outdated and unfair risk adjustment policies, implementing new policies such as applying a risk adjustment cap of no less than 5 percent and a downward cap no greater than -5 percent.
- CMS should align the use of a risk adjustment cap for the ACO and its region, applying a consistent capping policy to both.

Detailed Comments: Risk adjustment is an important aspect of setting fair ACO benchmarks and evaluating expenditures during the performance year. Accurate risk adjustment should remove or minimize differences in health and other risk factors that impact performance but are outside the ACO's control. NAACOS has repeatedly called on CMS to implement a more reasonable risk adjustment cap of no less than 5 percent while also applying a downward cap of -5 percent.

Though we appreciate the agency allowing risk score increases, CMS's application of a 3 percent cap is arbitrary and insufficient when applied across a five-year agreement. For example, assuming that an ACO

started in 2022, the most that the risk score used in the updated benchmark calculation can change in performance year five (2026) would be up to 103 percent of the 2021 risk score (based on 2020 Hierarchical Condition Categories (HCC) coding practices). The risk adjustment cap may be reasonable in early years of an agreement period, absent a global pandemic, but it is not reasonable when applied to later years of the agreement. Using MSSP PY 2017 results, 87 percent of ACOs would have had at least one enrollment type trigger the +/-3 percent cap when looking at the first three years of the agreement period. The average percentage capped in the first performance year of the agreement period is 88 percent, in the second performance year is 85 percent and the third performance year is 92 percent.

Risk adjustment caps are meant to control for outliers and avoid incentivizing coding intensity initiatives. However, these caps are a blunt instrument that can harm ACOs with more medically complex populations, which often include ACOs serving vulnerable communities. In the Pathways to Success rule, CMS found that 32 percent of ACOs would have greater than a 1.03 risk ratio for the Aged/Dual enrollment type over five years. This demonstrates that the current 3 percent cap is not appropriately set as it limits much more than outliers. **Therefore, we reiterate our previous request for CMS to change the risk adjustment cap to be no less than five percent and no greater than negative five percent.**

At the same time, NAACOS requests that CMS change the existing policy of capping each enrollment type separately and instead cap the risk ratios in aggregate across the four beneficiary enrollment types (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible). The different enrollment types often show significantly different cap rates based on a variety of factors such as sample size and volatility, and it is fairer to cap them in the aggregate.

Unfortunately, the COVID-19 pandemic highlighted another concerning aspect of the current risk adjustment methodology, which is the policy to cap the ACO while not capping the region. The inconsistency of capping one and not the other harms ACOs and is patently unfair. The pandemic introduced increased variation, and data show situations where a region's risk exceeds the cap, essentially creating an automatic penalty for an ACO in that market which cannot exceed the cap. For example, if an ACO's risk score goes up six percent and the region's risk score also increases six percent, the ACO's benchmark is reduced by a devastating three percent even though they simply matched their region. CMS data from the county public use files for 2020 confirms that this is not a small problem. This data shows that the average risk ratio for counties above 1.03 is 1.042 in the aged/non-dual population. That is 1.2 percent total cost of care gone for ACOs operating in those counties. For the dual population it is 1.055 so 2.5 percent total cost of care gone from the benchmark for this more vulnerable population.

Current policy is also driving inequity. Beneficiaries who are in the disabled and the aged-dual categories are, in most combinations, more than twice as likely to be above the cap as those who are in the aged non-dual category. Therefore, ACOs who disproportionately serve those beneficiaries, such as those composed of community health centers, are harmed twice as much by current policy. Essentially current policy means that ACOs that serve more vulnerable populations have a smaller budget with which to do so than ACOs that serve less vulnerable populations. The exact opposite of the goals outlined in the Executive Order[viii] On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.

While many, including CMS, did not anticipate this situation occurring often, the reality is that many ACOs have been harmed by this policy and will continue to be hurt by it until it is changed. It is important for CMS to take swift action to fix this and establish fair and consistent policies for ACOs. Therefore, **we urge CMS to align the use of a risk adjustment cap across the ACO and its region, applying the same cap to both. We also request that the agency make this needed correction retroactively, starting with**

performance year 2021. Doing so is fair to ACOs and sends a clear message of support from the agency to the ACO community.

Overall, it is essential that benchmarks reflect risk changes so that ACOs are fairly judged on their performance without being unfairly expected to manage an overall population's disease burden with virtually no changes during a five-year period. We appreciate CMS seeking feedback on ACO risk adjustment policies and urge the agency to implement the policy recommendations above.

MSSP Beneficiary Assignment

Proposals: CMS proposes to amend the list of primary care services it uses to assign beneficiaries to ACOs by adding seven codes starting in PY 2022. These include chronic care management, principal care management, and other evaluation and management (E/M) services. CMS also proposes to keep certain services temporarily added to the list of those eligible to be delivered via telehealth on the ACO assignment list through the end of 2023.

Comments: NAACOS supports updating the list 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. Maintaining an updated list of codes to include chronic care management (CCM), principal care management (PCM), and other E/M services is important to help determine where patients receive most of their primary care. As CMS notes, the proposed additions are similar to codes already on the ACO assignment list. As such, we recommend CMS finalize adding the seven proposed codes to the MSSP assignment methodology.

As stated elsewhere in this letter, NAACOS is a supporter of telehealth, which has been an important lifeline during the pandemic for patients to receive necessary care while avoiding risks of in-person visits during such a difficult time. Additionally, ACOs have relied on telehealth to maintain patient relationships during the COVID-19 public health emergency (PHE). This includes the use of audio-only telephone E/M services that were temporarily added to the list of those eligible to be delivered via telehealth during the COVID-19 PHE. Because of that, we also recommend CMS continue to keep using 99441, 99442, and 99443 in MSSP assignment until they are no longer payable under Medicare FFS policies.

Repayment Mechanisms

Proposals: Citing ACO administrative and financial burdens of securing repayment mechanisms, CMS proposes to ease requirements. Specifically, the agency proposes to cut in half the current repayment mechanism amounts, which if finalized would result in ACOs paying the lesser of either: (1) one-half percent of the total per capita Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries; or (2) 1 percent of the total Medicare Parts A and B FFS revenue of its ACO participants. CMS also considered, though did not propose, an alternative approach for calculating repayment mechanism amounts by using a per beneficiary dollar amount, based on a percentage of actual historical median per capita shared losses for ACOs, multiplied by an estimate of the size of the ACO's assigned population as identified during the annual application or annual change request cycle.

The agency also proposes to drop a requirement that ACOs increase their repayment mechanism amounts should they increase by 50 percent. CMS would also allow certain ACOs with repayment mechanisms already in place to reduce the amount of their repayment mechanisms should the required amounts decrease under the revised policies, if finalized.

Key comment:

- NAACOS recommends CMS finalize its proposal to cut in half the repayment mechanism amounts required for ACOs in shared risk models.

Detailed comments: Securing a repayment mechanism is a regulatory burden, which is time consuming and costly for ACOs. Many ACOs cite the burden and cost of securing a repayment mechanism as reasons not to move to a risk-based ACO model. We appreciate CMS proposing ways to minimize burdens associated with repayment mechanisms. NAACOS has previously urged CMS to cut in half the amount of the repayment mechanisms, such as in our comments[4] in response to the Pathways to Success Rule. Therefore, we strongly support CMS's proposal to reduce the required repayment mechanism amounts by 50 percent and urge the agency to finalize the proposal. Those amounts are sufficient to prompt third-party due diligence and establish credit worthiness within the probable range of shared losses. This reduction makes sense in light of the MSSP loss sharing rates and shared loss limits that correspondingly reduce the likelihood of net losses.

NAACOS also strongly supports CMS's proposal to remove the requirement that ACOs increase their repayment mechanism amounts if they increase by 50 percent. We recommend CMS finalize removing this requirement in favor of a revised policy under which ACOs would only have to update their repayment mechanism amount if it increases by at least $1,000,000. This minimizes burdens and costs for ACOs, allowing them to focus their limited time and resources on care coordination interventions as opposed to unnecessary administrative requirements. We also appreciate CMS noting in the proposed rule that if these policies are finalized the agency will allow certain ACOs with repayment mechanisms already in place to reduce the amount of their repayment mechanisms should the required amounts decrease under the revised policies. It is fair to permit such a decrease for ACOs with repayment mechanisms already in place.

While NAACOS supports CMS's effort to minimize cost and burdens with repayment mechanisms, we request that the agency go further. Specifically, we urge CMS to:

- **Eliminate the 12-month "tail period" that requires ACOs to maintain the repayment mechanism for a year beyond the expiration of their agreement period.** This additional burden is costly and unnecessary and should be removed.
- **Provide flexibility for ACOs that may need to adjust their repayment mechanisms over time.** For example, we request the agency work with ACOs to provide flexibility to release funds for a limited window, such as 60 days, for ACOs changing repayment mechanisms.
- **Reinstate reinsurance as a repayment mechanism and introduce an option for a future withhold of Medicare payments as repayment mechanisms**. We request CMS restore reinsurance as a qualifying repayment mechanism, which it was until CMS removed it in the June 2015 final MSSP rule.

Beneficiary notification

Proposals: CMS currently requires that ACO participants post signs and provide written notice that its providers are participating in the Shared Savings Program, that beneficiaries may decline claims data sharing, and that beneficiaries may identify or change their primary clinician. CMS proposes to alter the current beneficiary notification requirements such that ACOs that have selected prospective assignment would not be required to send written notice to beneficiaries who are not assigned to the ACO for the relevant performance year. Under the proposed policy, ACOs that have selected prospective assignment must provide standardized written notice to each prospectively assigned beneficiary prior to or at the first primary care visit of the performance year.

Comments: NAACOS appreciates CMS's efforts to remove an unnecessary burden on certain ACOs. The proposed changes would help reduce burden on ACOs and eliminate potential confusion among beneficiaries who, under current policy, are required to receive notice that describes details that will not

apply to them. NAACOS has repeatedly advocated for the removal of the burdensome beneficiary notification requirements in a 2019 letter,[ix] letters in February[x] and May[xi] of 2021, and again in 2021.[xii] Therefore, we support this proposal to amend the beneficiary notification requirement such that ACOs that have selected prospective assignment do not have to send notification to beneficiaries that are not prospectively assigned to them. However, we urge CMS to take a step further in reducing burden for ACOs by removing the beneficiary notification requirement altogether.

Beneficiary notifications were required as part of the MSSP in the early years of the program, but the requirement was later removed due to the administrative burdens, beneficiary confusion, and operational complexity caused by the notifications. Since then, CMS has reintroduced the requirement with new specifications per the Pathways to Success Rule. This requirement has a significant cost associated with it and has created confusion among both ACOs and the patients they serve. As a result of the notifications, some beneficiaries choose to opt-out of data sharing without understanding what the data sharing process entails, making it difficult for ACOs to coordinate and manage patients' care effectively. If CMS feels it is necessary to inform patients about ACO goals and objectives beyond the posted notices that are already a requirement of the MSSP, NAACOS feels it is more appropriate for the payer (i.e., CMS) to issue such notifications, which would eliminate the issue of patients receiving notifications from multiple ACOs and reduce the cost and burden currently placed on ACOs.

Application process

Proposals: CMS has reviewed the MSSP application process and found that document submission requirements substantially increase burden without adding significant value to the application review process. To alleviate burden, CMS proposes several changes to the application process, including eliminating requirements that ACOs inform CMS about past participation. Instead, it would only be required if CMS requests it. CMS also proposes to remove requirements that ACOs submit sample participant agreements during the application process. These too would only be required at CMS's request. Lastly, CMS proposes to modify the requirement that ACOs must submit an executed ACO participant agreement for each ACO participant at the time of its initial application and during the renewal process. Instead, ACOs would only be required to submit agreements during initial application and when requesting additions to their ACO participant list.

Comments: NAACOS supports the proposals to streamline and simplify the MSSP application process in order to reduce burden on ACO applicants. The administrative burdens of paperwork, submission, and resubmissions can be onerous for ACO applicants on top of the significant work they are already required to do for the program. Therefore, NAACOS appreciates efforts by CMS to reduce this burden and requests the agency finalize these proposals. In addition to this, we recommend that CMS move the deadline for adding participants until later in the year (e.g., move from August 3 to September), as early August is a very limiting deadline for ACOs attempting to project into the next year. We also recommend that CMS inform efforts to further improve the application process by surveying ACOs to understand the potential impact of changes on participants in advance. This could help lead to more effective changes and successful implementation. In line with this increased transparency and dialogue between the agency and ACO participants, NAACOS also recommends that CMS grant ACOs access to view the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) from the ACO Management System (ACO-MS), which could help resolve discrepancies.

QPP and MEDICARE PFS PAYMENT POLICIES

Evaluation and Management Visits (E/M)

Proposals: CMS proposes certain updates in response to evolving care delivery, such as a shift to team-based care and APMs, like ACOs. Proposed policies focus on split or shared visits, critical care services, and teaching physician visits. The proposed rule clarifies that those physicians in a facility setting may bill for a split/shared visit only if they perform a substantive portion of the visit. CMS also proposes to limit the definition of a split/shared visit to include only E/M visits in institutional settings for which "incident to" payment is not permitted under Medicare rules. For critical care services, CMS clarifies new billing policies, proposing to prohibit practitioners who report critical care services from reporting any other E/M visit for the same patient on the same calendar day or during the same time period as a procedure with a global surgical code. The agency proposes to allow split billing for critical care services. Finally, CMS proposes to clarify that only the time a teaching physician is present can count toward E/M visit level for teaching services with a "primary care exception" that allows for payment for certain low and mid-level complexity services furnished by a resident without the physical presence of a teaching physician in certain teaching hospital primary care centers.

Comments: NAACOS appreciates CMS's acknowledgment of the need to review payment, guidelines, and documentation requirements for billing E/M visits. NAACOS continues to support CMS's efforts to modernize E/M payment to support evolving care delivery with the goal of higher quality, lower cost patient care. We support CMS's proposals to clarify policies for split/shared visits and critical care services. These clarifications help to give credit for the use of necessary team-based care, which supports coordinated, whole-person care delivered by ACO providers. CMS should continue to focus on revisions that support the overall goal of paying for value rather than paying for volume.

We also support the proposed notable primary care exception for payment of E/M visit level for teaching services, which will allow payment for certain low and mid-level complexity services provided by a resident in certain primary care centers without the presence of a teaching physician. NAACOS believes that these resident primary care physicians have the capacity to effectively furnish such low and mid-level complexity services. Allowing this exception will likely increase access to primary care at this critical time of primary care clinician shortages across the nation.

Chronic Care Management (CCM) Services

Proposals: As part of evaluating payment for Medicare services, the CMS considers updates to care management services. For CY 2022, the American Medical Association (AMA) Resource-Based Relative Value Scale (RVS) Update Committee (RUC) resurveyed the CCM code family, including Complex Chronic Care Management (CCCM) and PCM, and added five new CPT codes (99X21–99X25). CMS proposes to pay for these new codes in Medicare effective beginning in 2022. CMS also proposes to replace codes G2064 and G2065 with CPT codes 99X22 and 99X24, respectively. The agency also proposed to accept the RUC-recommended values for the codes as well as for five additional existing CCM codes that would all have RVU increases should CMS finalize its proposed revaluations. The agency also seeks comments on obtaining beneficiary consent for care management services.

Comments: We greatly appreciate CMS's efforts to enhance the use and value of care coordination and care management services. These are designed to better manage patients' chronic conditions and care transitions to help them avoid more intensive treatment and care settings by keeping them healthier, thus improving their quality of life. Successful care coordination is a foundational element of ACOs' work and these codes are frequently used by ACOs. We also support CMS finalizing the use of CPT codes as

opposed to temporary G-codes, which streamlines use of these services across the healthcare industry. We recommend CMS finalize the proposed payment increases and use of CPT codes as proposed.

NAACOS previously has expressed concerns about the burdens associated with obtaining beneficiary consent, and we appreciate CMS raising this issue in the proposed rule. CMS allowed general supervision during the COVID-19 PHE, and we request the agency permit this flexibility beyond the PHE which limits burdens associated with obtaining consent. While we support this flexibility, we request the agency go further to minimize burdens associated with the beneficiary consent. Specifically, we request CMS work with Congress to remove this requirement altogether, which would increase utilization of these services and therefore improve beneficiary care management.

Telehealth and Other Services Involving Communications Technology

Key comment:

- CMS should use its statutory authority 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.

NAACOS continues to urge CMS to expand telehealth in ways that are thoughtful, clinically meaningful, and that ultimately improve patient care. We reiterate our belief that APMs, especially ACOs and other total-cost-of-care, value-based payment arrangements, 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.

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 CMS Innovation Center 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 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. 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.

Revised Timeframe for Services Temporarily Added to the Telehealth List

Proposals: CMS proposes to keep all of the services it added to the list of those eligible to be delivered via telehealth through the end of 2023, regardless of when the PHE ends. CMS also proposes to permanently cover G2252 (a "virtual check-in" between 11 and 20 minutes) beyond the PHE.

Comments: NAACOS generally supports maintaining the temporarily expanded telehealth list through the end of 2023. If the Department of Health & Human Services (HHS) extends the PHE or Congress prolongs the coverage of telehealth beyond the PHE, having access to these codes will be important. However, we reiterate our call that CMS minimize the regulatory burden associated with virtual check-ins. This red tape has caused uptake of the services to be slow. 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.

Telehealth for Mental Health

Proposals: CMS proposes to make a patient's home a permissible originating site for the diagnosis, evaluation, or treatment of mental health disorders via telehealth. However, CMS proposes that beneficiaries must have an in-person visit within six months before the date of their at-home telehealth service. CMS proposes to allow audio-only tele-mental health services delivered at patients' homes and to limit payment for audio-only services for clinicians who have the capacity to furnish two-way, audio/video telehealth but the beneficiary is unable to use, does not wish to use, or does not have access to two-way, audio/video technology.

Comments: NAACOS generally supports the expansion of telehealth for mental health. Greater access to mental health care is needed. CMS's proposed changes would greatly expand the reach of tele-mental health.

NAACOS appreciated CMS's work to provide broader coverage of audio-only services during the COVID-19 PHE. Audio-only will still be critical once the PHE is lifted as many seniors will continue without access to video-based visits. However, NAACOS reiterates its belief that audio-only visits should not be reimbursed at the same level as video-based telehealth. Phone-based visits often deliver less clinical value than video-based visits because of non-verbal communication that is missed, among other differences. While there is a place for audio-only telehealth, it shouldn't be reimbursed at the same level and should be limited to certain situations and patients who may not be able to use video-based telehealth.

Remote Therapeutic Monitoring

Proposals: CMS proposes to add five new "remote therapeutic monitoring" (RTM) codes in 2022 that, if finalized, will cover the collection and interpretation of "non-physiologic" patient data, such as that for musculoskeletal system status, respiratory system status, medication adherence, and medication response. CMS would require the use of a medical device approved by the Food and Drug Administration (FDA) for RTM services as it does with remote physiologic monitoring (RPM), but the agency proposes that non-physiologic data may include self-reported data. The agency proposes payment rates equivalent of that for RPM services.

Comments: NAACOS supports the use of remote monitoring technology as an effective way to manage the long-term health of chronically ill patients in a cost-effective manner. We remain concerned that making remote monitoring services, including newly proposed RTM codes, too easy to bill might make them susceptible to fraud, abuse, and overuse. Necessary precautions, such as CMS's proposal to require remote monitoring technology to be approved by the FDA, will help mitigate fraud, abuse, and overuse. However, CMS should reconsider allowing self-reported data, which is often unreliable and opens the door to fraud and misuse. NAACOS voiced similar concerns in our comments to last year's proposed

Physician Fee Schedule. We commented then and reiterate here that patients' self-reporting pain for post-surgery recovery is not a good use of RPM services. CMS could consider 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.

Advanced Alternative Payment Models (APMs)

Proposals: CMS acknowledges the complexity of distributing Advanced APM bonuses when clinicians are no longer practicing at TINs associated with earning their Advanced APM bonus. The agency proposes to modify its process for identifying QPs who change organizations following the performance year. Specifically, CMS's proposed change would maintain the current hierarchy for attempting to find and pay these clinicians, described in regulations at § 414.1450(c) while adding a sub-step at each level in which the agency would conduct the search based on more current Medicare enrollment information, as identified in the PECOS. The proposed change would focus identification of an appropriate TIN or TINs at each step by first checking the base year, which is the year between performance and payment years, and then checking the payment year before moving on to the next step in the process.

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, further incentivizes the shift to value, and reduces complexity for the agency to track down clinicians to make these payments.

Beyond the minor proposal to adjust how CMS identifies and pays eligible clinicians (ECs) who change organizations after the performance year, CMS does not make notable Advanced APM proposals in this rule. The agency estimates that for PY 2022, which corresponds to the 2024 payment adjustment year, there will be between 225,000 and 290,000 eligible clinicians who qualify for 5 percent Advanced APM incentive payments. CMS estimates aggregate bonuses will total between $600 million and $750 million. Both the number of qualifying participants (QPs) and the aggregate bonus amounts are not major increases from previous years. It is disappointing that these numbers have stagnated, which does not meet the congressional intent of the Medicare & CHIP Reauthorization Act (MACRA) to increasingly shift providers from FFS and MIPS to Advanced APMs.

We urge CMS to work with Congress to remove barriers to Advanced APM participation, such as by reducing or eliminating the QP thresholds. NAACOS and other leading national healthcare associations also continue to advocate[xiii] that Congress extend the Advanced APM bonus for six additional years, which is a provision of the NAACOS-supported Value in Health Care Act (H.R. 4587). This bill would bolster the transition to Advanced APMs and reinforce the MSSP through positive policy changes. Importantly, a recent independent analysis[xiv] shows the bill would save an estimated $280 million over 10 years.

MIPS Requirements

MIPS Data Completeness

Proposals: CMS proposes to increase the quality data completeness requirement from 70 percent to 80 percent.

Comments: NAACOS opposes this increase, as when applied to ACO quality assessments it is inappropriate and would significantly expand the measure denominators for ACOs. Instead, we urge CMS to apply the policies outlined in our letter above to ACO quality assessments.

However, should CMS instead move forward with an all-payor requirement for ACOs which NAACOS opposes, we request CMS lower the data completeness level to no more than 40 percent with a gradual increase to a maximum of 50 percent for those reporting eCQMs or MIPS CQMs. Another alternative would be for CMS to 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 approach would ensure that ACOs perform well on a substantial set of measures to earn savings, but it 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.

MIPS Final Scoring and Projected MIPS Scores for 2021

Proposals: CMS estimates a score of 100 in PY 2022 could earn an approximately 14 percent positive adjustment in the 2024 payment year based on these proposed performance thresholds. However, CMS also notes it anticipates there could be higher performance and therefore fewer clinicians receiving penalties which would lower the maximum positive adjustment to potentially lower than 9 percent. The maximum negative adjustment in PY 2022 is -9 percent, as required by statute.

Comments: NAACOS is concerned that the balance of rewards for participation in FFS Medicare versus an APM is now resulting in incentives that could potentially be higher for participation in FFS Medicare. CMS should be incentivizing clinicians to participate in APMs.

MIPS Quality Benchmarks for 2022

*Proposal*s: CMS proposes to establish MIPS quality benchmarks using PY 2022 data or 2019 data, due to anomalies in the 2020 data set due to COVID-19. Please note that these quality benchmarks are now used in the MSSP.

Comments: NAACOS supports CMS efforts to minimize data issues resulting from COVID-19 by avoiding use of 2020 data in establishing quality benchmarks. We urge CMS to also evaluate 2021 data to determine if there are data anomalies that will require avoiding use of this data as well. As stated above, we urge CMS to rely on 2019 data in establishing benchmarks for ACOs so that ACOs can know quality measure benchmarks prior to the start of the performance period; therefore we request the agency also use this approach broadly for MIPS.

Hierarchy When Multiple Final MIPS Scores Exist

Proposals: CMS proposes to again modify the hierarchy used when multiple final MIPS scores exist for a clinician. Table 61 (p. 39458) summarizes these proposed changes for 2022 by providing a scenario example for when multiple final MIPS scores exist. Specifically, CMS proposes to update the scoring hierarchy to include subgroups and to specify that the scoring hierarchy would apply with respect to any available final score that is associated with a TIN/National Provider Identification (NPI) from MVP, traditional MIPS and/or the APP. This adds an incredible amount of complexity, and NAACOS has reached out to CMS to clarify how this will work in conjunction with ACO scoring, particularly if an individual EC or TIN chooses to report outside the ACO.

Comments: NAACOS is deeply concerned with the complexity resulting from allowing subgroup participation in MIPS via the MVP framework proposals. Additionally, we continue to have concerns with allowing ACO clinicians to report outside the ACO as this introduces more complexity and confusion to an already very complicated process. We instead urge CMS evaluate ACO performance at the ACO level only for purposes of MIPS evaluations.

Advancing to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Hospital Quality Programs RFI

CMS issued a request for information in the proposed rule on its goal to move to a fully digital quality measurement system for value-based purchasing programs by 2025. CMS plans to expand the use of Fast Healthcare Interoperability Resources (FHIR) standards and application programming interfaces (APIs) for both current eCQMs and future measures to help facilitate this goal. The agency believes advancements in the interoperability of health data will make digital quality measurement possible by 2025. CMS seeks information on its goal to move to digital quality measures (dQMs) and various details of the transition.

Comments: NAACOS appreciates CMS's efforts to solicit feedback on goals for digital quality measurement. This important issue needs long-term planning and foresight that is gained by requests for information such as this. NAACOS also appreciates the need to simplify quality measurement in value-based purchasing programs, including Medicare ACO models. We believe this is achievable as advancements are made in the implementation of FHIR standards, APIs, and the general interoperability of disparate health IT (HIT) systems in use.

However, NAACOS is deeply skeptical of the feasibility for the healthcare industry to meet CMS's stated goal to move to a fully digital quality measurement system for value-based purchasing programs by 2025. As discussed in this comment letter above, numerous technical hurdles exist in moving to eCQM reporting, most notably the inability to aggregate data from different EHR systems. Additionally, health IT systems often extract data from clinical notes differently, resulting in the appearance of different performance of clinicians who treat the same sets of patients equally. Standards, including FHIR, do not harmonize data quality. The inclusion of additional data sources, the collection of that data, and lack of specificity within these standards result in quality measurement that does not accurately reflect the care being delivered. These issues were highlighted by extreme challenges for ACOs identified in response to CMS's MSSP quality overhaul plans, but the same challenges will also exist for other value-based payment program participants. HHS and CMS need to do more to address underlying problems *before* attempting to move to a fully digital quality measurement system.

These fundamental issues won't be easily solved even as advancements in health IT interoperability are made. In fact, many of these problems are exacerbated in ACOs whose participating providers use numerous EHRs. According to a NAACOS survey of ACOs, nearly half of ACOs' participating practices use 11 or more EHRs. **NAACOS strongly encourages CMS to not put a specific date by which the agency plans to move to full digital quality measurement.** Instead, the healthcare industry would be better served by making the full transition only after necessary HIT advancements have been made, which likely will not occur by 2025. Evidence from the past decade shows how it was necessary for CMS to delay or ease requirements related to numerous health IT initiatives, which resulted from unrealistic timelines that were not feasible for government, vendors or providers. HHS and CMS should focus more on supporting important health IT transformations and getting them right rather than setting exact dates for certain actions. Our nation's health IT systems may not be fully interoperable by 2025, even as 2020's information blocking rules take effect, and dQMs will be another example of a barrier to full interoperability.

Digital quality measure information should help inform decisions to provide the best care for a patient, or population of patients. However, in order to realize that goal, the data must be uniformly structured and in an acceptable format across multiple EHRs when requiring ACOs or other value-based payment program participants to aggregate data. While the Office of the National Coordinator for Health Information Technology (ONC) requires eCQMs to be collected and reported by 2015 Edition Certified EHRs, there is no requirement for them to be aggregated from disparate systems. Nor does guidance exist for eCQMs to be collected in a standard or uniform manner. From our spring survey of ACOs, the biggest barrier cited for movement to eCQM reporting was the lack of EHR standardization. While FHIR standards can be very effective in a setting where one standard EHR and standard workflows are in place, when attempting to aggregate data as an ACO, these standards are not a panacea when attempting to aggregate data as an ACO, and the process is often very costly. EHR vendors would need to be universally interoperable in order to maximize the effectiveness and usefulness of FHIR standards.

NAACOS encourages CMS to take the following actions:

1) Address other issues regarding ACO quality measurement we raise elsewhere in this letter. Issues such as reporting on all payers across an ACO, de-duplicating patients, creating measures reflective of specialists, and many others won't be solved by the move to dQMs.
2) Articulate an industry-wide, multi-year plan to move to dQMs, including necessary actions from providers, ACOs, EHR vendors, and federal agencies. This plan should be detailed with concrete actions, not visionary, and developed in close consultation with industry partners. NAACOS and ACO members should be part of that development, along with other industry leaders across the healthcare and health IT communities.
3) Monitor vendor and ACO progress in transitioning to eCQMs and dQMs to ensure any deadlines are reasonable. As stated above, a 2025 transition to a fully digital quality measurement system is highly unreasonable. Instead, checkpoints should be established for the transition, and CMS should only move to the next phase after a checkpoint is met.
4) Work with ONC to better drive eCQM adoption. CEHRT doesn't drive eCQM adoption. This should change. Currently, EHR vendors have little incentive to prioritize what eCQMs they build into products, particularly for specialists who have little economic sway, including data reporting structure guidance and mapping data to required reporting specifications.
5) Prioritize the incorporation and aggregation of clinical data and aggregating of data from disparate EHR systems before working to bring in patient-generated health data, as CMS suggests it is thinking about in the rule. Combining data from two different EHR systems that don't "talk" to each other should be addressed before working to integrate non-clinical or non-EHR data.
6) Effectively communicate EHR specifications to help developers so that they can successfully build products and capabilities. NAACOS heard from EHR developers late this spring that they hadn't received necessary information about eCQMs that ACOs had been required to report. Such delays make it difficult, if not impossible, for ACOs and the EHRs that serve them, and also contributes to unbudgeted and avoidable costs encountered by ACOs and EHR vendors.

While NAACOS generally supports the movement toward use of eCQMs and digital quality measurement sources to reduce certain burdens in quality reporting among ACOs, this transition will only reduce burdens and advance quality if done right. We appreciate this opportunity to provide additional input from an ACO standpoint of data collection, reporting and assessment using digital quality measures, and we look forward to continuing to work with CMS to help chart a successful long-term transition that will benefit patients and providers.

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

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i https://www.naacos.com/aco-coalition-letter-on-mssp-quality-overhaul
ii https://www.naacos.com/final-naacos-comments-on-proposed-2021-mpfs-rule
iii https://www.naacos.com/assets/docs/news/finalacobenchmarkingnprmcoalitioncommentletter0325016.pdf
iv https://www.naacos.com/assets/docs/pdf/FinalNAACOSCommentsonProposedPathwaystoSuccessRule101518.pdf
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vi https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0840
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xii https://www.naacos.com/index.php?option=com_content&view=article&id=1317:brooks-lasure-letter&catid=20:site-content
xiii https://www.naacos.com/press-release--fourteen-leading-health-groups-support-value-in-health-care-act
xiv https://www.naacos.com/press-release--national-health-groups-ask-congress-to-include-aco-bill-in-reconciliation-package