October 2, 2020

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

Via Electronic Submission at Regulations.gov

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

Dear Administrator Verma:

Evolent Care Partners (ECP) supports independent primary care physicians by providing the capital, clinical and operational resources needed to remain independent and succeed within two-sided risk arrangements. As we move into 2021, ECP's footprint of more than 1,400 independent providers spans six states – Indiana, Michigan, North Carolina, Texas, California, and Utah. As a Medicare Shared Savings Program ENHANCED Track accountable care organization (ACO), we serve 88,000 Medicare beneficiaries and manage nearly $1 billion in medical expense. While working to reduce administrative burden for independent physician practices, improve patient care and lower costs, ECP aligns its value-based care delivery and risk models across multiple public and private payers. As the primary care partnership arm of Evolent Health, ECP leverages more than a decade of ACO, provider-sponsored health plan, and population health experience and capabilities; as well as sophisticated predictive analytical tools and specially trained clinical teams that proactively identify patients with impactable risk and intervene with proven care coordination programs.

ECP's comments to the CY 2021 Medicare Physician Fee Schedule Proposed Rule (CMS–1734–P) are focused primarily on policies pertaining to the Medicare Shared Savings Program (MSSP, section III.G.) and the Quality Payment Program (QPP, section IV.).

Evolent has a long history of driving health care quality performance and improvement. We fully support the Agency's commitment to advancing value in health care – including requiring that ACOs take on increasing risk over time through "Pathways to Success" – and its focus on raising the bar on quality over time. **However, we are extremely concerned that the MSSP quality program overhaul as proposed to begin in 2021 would *disproportionately disadvantage independent physician ACOs*. By CMS's own account, these ACO entities are out-saving their hospital-system led ACO peers in the program with net savings of $201 per beneficiary compared to $80 per beneficiary for high-revenue ACOs.**

Furthermore, MSSP ACOs generated net Medicare savings for the third year in a row, and the largest annual savings to-date at $1.19 billion in 2019. ACOs continued to show comparable or better performance on quality measures compared with other physician groups; and the program maintains strong incentives for ACOs to deliver more coordinated and efficient care for Medicare beneficiaries.

We commend CMS's significant efforts to reduce health care provider burden and provide significant resources and flexibilities during the COVID-19 national public health emergency, including expanded use of telehealth. We agree that providers should be able to focus on providing the highest quality care for their patients without undue burden. Unfortunately, the proposals to overhaul ACO quality measurement and reporting as put forth in this year's Medicare physician fee schedule proposed rule are inconsistent with these goals.

Medicare Shared Savings Program ACO Quality Reporting and Scoring

CMS has proposed a major overhaul of MSSP quality measurement reporting mechanisms, decreased the number of quality measures to be reported and proposed a higher quality performance standard. These changes would take effect January 1, 2021 after a shortened public rulemaking period, when providers are still examining and recovering from the impacts of the COVID-19 public health emergency on our nation's health care system. ***We oppose these proposals and recommend that the Agency meet with stakeholders in 2021 to discuss alternative policies. Specifically:***

1. **We recommend that CMS retain the option for ACOs to report quality through the CMS Web Interface rather than through Merit-based Incentive Payment System (MIPS) Clinical Quality Measures (CQMs) or eCQMs.** Participating in an advanced alternative payment model (AAPM) offers providers significant benefits in exchange for taking on financial risk and transforming care. One is the opportunity for participating eligible clinicians to earn a 5% AAPM bonus payment. Another is the opportunity to be excluded from the more burdensome MIPS quality reporting processes and payment adjustments. Congress' goal for the two-pronged Quality Payment Program – enacted with broad, bipartisan support in the Medicare Access and CHIP Reauthorization Act of 2015 – was to increase the uptake of AAPMs and decrease inefficient fee-for-service payment systems, and thus the need for MIPS, over time. Instead, the proposed rule would take a step backwards by aligning AAPM quality reporting and scoring methodologies with those used by providers in MIPS.

   Importantly, what works in MIPS for a single physician group practice or hospital system operating on a single electronic health record (EHR) system would not be appropriate for a large multi-physician practice ACO managing population health and total cost of care for their aligned Medicare patient population. Unlike the CMS Web Interface which uses beneficiary sampling for quality measurement, CQM and eCQM reporting mechanisms would require ACOs to report on 60-70% of their patients, including those outside of the ACO and those of other payers. Evaluating ACOs on all

patients they serve rather than their aligned ACO population would not provide a true measure of ACO quality performance and would skew ACO evaluations due to spillover effects. Furthermore, this proposal may raise legal or contractual concerns around accessing patient data.

ACOs have made significant investments to develop and refine reporting processes and workflows over time. The Agency's quality reporting overhaul would require new, significant investments of time, money, and effort to create new workflows, re-train staff, pay for registries, and adapt EHRs to comply with eCQM standards. These would need to begin in December 2020, as soon as the final rule is published (later than normal) and as providers still manage and recover from an unprecedented national public health emergency. The proposal would disproportionately disadvantage smaller and rural ACOs and multi-practice independent physician ACOs operating many EHR systems. Again, these are the very ACOs that – as CMS has pointed out – have been consistently outperforming their hospital system-based ACO peers.

2. **We recommend that CMS not finalize its proposal to reduce the set of ACO quality measures from 23 to six measures, with just three measures reported by the ACO.** While we agree with the general intent of this proposal to reduce provider burden, reducing the measure set drastically with almost no transition time would do the opposite. Rather than domain-based measurement with some built-in flexibility including pay-for-performance phase-in and the opportunity to earn bonus points, this all-or-nothing approach would burden ACOs with more heavily weighted measures. Such a significant reduction in measures also removes important quality improvement nuances within and across ACOs, making very small differences in quality appear much larger.

   We recommend that the Agency gather more stakeholder input on potential future changes to the ACO measure set and on how changes should be phased in to minimize disruption. For example, CMS's proposed claims-based hospital utilization measures, comprising one-third of the reduced measure set, use clinical rather than social risk adjustment. As in the Hospital Readmission Reduction Program, this approach could disadvantage ACOs serving populations with disproportionately higher social risk factors.

3. **We recommend that CMS not finalize its proposed higher minimum performance standard for MSSP ACOs to receive shared savings.** The Agency has proposed delaying the MIPS Value Pathways approach for 2021 given the COVID-19 pandemic to allow more time to assess clinicians' readiness to make the transition. Shared Savings Program ACOs should be given the same consideration. We agree that quality is a critical component of the move to value in health care, and again, we fully support raising the bar on quality over time. However, ACOs need time to transition to major new requirements, and quality benchmarks must be known in advance. CMS proposed to use all MIPS reporters and performance year (PY) 2021 data to establish ACO quality benchmarks given COVID-19 impacts in 2020 that would skew quality

data. ACOs would have similarly limited line of sight into how COVID-19 has impacted quality metrics in 2020 and how to measure and perform against an unknown set of benchmarks in 2021.

MSSP Extreme and Uncontrollable Circumstances Policy

We thank the Agency for developing the Extreme and Uncontrollable Circumstances Policy (EUC) for MSSP ACOs and the many flexibilities provided to providers and ACOs in 2020. Our recommendations on these policies are as follows:

1. **Finalize the proposal to modify the EUC for the 2020 performance year by applying an ACO's 2020 quality performance score or the score applied in its 2019 financial reconciliation.**

2. **Should the COVID-19 public health emergency carry over into 2021, CMS should also implement this policy for the 2021 performance year – apply the higher of the ACO's 2021 quality performance score or the quality score used in its 2020 financial reconciliation (per the EUC policy in #1 above).**

3. **Finalize the proposal to waive the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey requirement in 2020 and grant full credit for these 10 measures for the 2020 performance year.**

Taken together, these policies strike the right balance that recognizes major health care utilization changes and beneficiary sampling challenges associated with the COVID-19 public health emergency.

For subsequent years, CMS proposes to modify the EUC policy based on the higher of an ACO's quality score or a score equal to the 40th percentile MIPS Quality Performance Category Score. For ACOs that could not complete quality reporting or meet the performance standard, CMS proposes to adjust shared savings by length of time and percentage of the ACO's assigned beneficiaries affected by the EUC. **We recommend that CMS not finalize these proposed longer-term changes to the EUC policy and instead allow for more time to examine pandemic impacts and gather stakeholder input on potential alternatives for 2022 and beyond.**

Proposed CY 2021 Updates to the Quality Payment Program

As discussed previously, we support the continued growth and success of advanced APMs such as performance-based risk ACOs and disagree with the general direction of aligning these innovative models with various MIPS program methodologies. The guiding principle should be to ensure that AAPMs retain strong incentives relative to fee-for-service, including in their program's design and implementation.

The opportunity to earn a 5% bonus through meaningful participation in an AAPM is a strong incentive. However, as we and others have pointed out there are several flaws to the methodology used to determine Qualifying APM Participant (QP) status in the Quality Payment Program (QPP). For example, it is significantly harder for ACOs using prospective beneficiary assignment to meet or exceed the QP thresholds due to patient and provider churn occurring between MSSP's prospective claims-based assignment lookback period and the QP determination snapshots during the performance year. In contrast, these two periods overlap for retrospective assignment ACOs. These differences – *which reflect merely program design choices and not the level of meaningful participation in an AAPM* – are only exacerbated as payment amount and patient count QP thresholds are set to increase dramatically in 2021.

Based on our analysis of March 2020 QP scores for AAPM-level MSSP ACOs, nearly 42% of retrospective assignment ACOs (33 out of 79) currently meet or exceed the PY21 QP payment amount threshold, whereas *that number drops to 4% of prospective assignment ACOs* (4 out of 91). *A staggering 44% of prospective assignment MSSP ACOs are at risk of failing to meet either of the PY21 thresholds, versus just 15% of retrospective assignment ACOs*. As prospective assignment is used more often by higher-risk track, more sophisticated ACOs, these are the entities contributing most to the program's success. This is one example of several unintended consequences of the QP threshold methodology that CMS (and Congress, where needed) should address to ensure the MACRA AAPM bonus incentive remains a strong incentive to move to value.

For the CY 2021 Medicare Physician Fee Schedule, CMS proposed just one change to the QP threshold calculation. **We agree with the accommodation proposed to exclude beneficiaries from the QP "attribution eligible" denominator if they could not possibly be in the "MSSP attributed beneficiary" numerator**; for example, beneficiaries who were prospectively assigned to another ACO or other AAPM during the QP performance period. We also remain concerned about the existing QP threshold disparity between retrospective and prospective assignment ACOs, and we hope that the proposed methodology change would not exacerbate that disparity in any unforeseen ways.

To maintain fairness and avoid further unintended consequences, we recommend that CMS make conforming accommodations for prospective assignment ACOs. Specifically,

- **For prospective assignment ACOs, CMS should exclude beneficiaries from the QP denominator if they were not eligible for ACO assignment during the claims-based prospective assignment lookback period.** For example:
    - Beneficiaries who had no primary care services from a physician during the assignment window.
    - Beneficiaries who did not gain Medicare eligibility until after the close of the assignment window.

These conforming changes for prospective assignment ACOs would reduce the impact of assignment methodology choices on QP scores and apply a more consistent approach across

the program. **Finally, we thank the Agency for establishing a targeted review process for QP determinations in cases of errors or omissions.**

Thank you for your consideration of these recommendations. The Medicare Shared Savings Program is as important in this moment for ensuring the best possible health outcomes for the Original Medicare population as it has ever been. We look forward to our continued dialogue on ways to ensure the program's continued success and sustainability.

Sincerely,

Asit Gosar, Chief Executive Officer
Jessica Landin, Chief Operating Officer
Chris Dawe, Chief Growth Officer
Nico Lewine, Chief Transformation Officer
Ashley Ridlon, Vice President, Health Policy