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Via Electronic Submission (www.regulations.gov)

February 6, 2015

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-1461—P
7500 Security Blvd.
Baltimore, MD 21244-8013

Dear Ms. Tavenner:

Re: Medicare Shared Savings Program, File Code CMS-1461-P

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS' or the Agency's) proposed rule entitled *Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations*, 79 Fed. Reg. 72760 (December 8, 2014). The AAMC represents a not-for-profit association representing all 141 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, and 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

The AAMC supports alternative payment model (APM) programs that seek to promote high-quality, efficient care while retaining at their core the essential patient-physician relationship. Chief among these efforts are accountable care organizations (ACOs) and bundled payments initiatives. Academic medical centers (AMCs) have been leaders in testing new payment models, including Pioneer ACOs and Medicare Shared Savings Program (MSSP) ACOs. AAMC is also a facilitator-convenor for the Bundled Payments for Care Improvement (BPCI) initiative for 30 hospitals and 19 health systems.

The MSSP program has the potential to lower cost, improve care coordination, and provide savings to Medicare. The Department of Health and Human Services (HHS) recently stated a goal of tying 30 percent of fee-for-service (FFS) Medicare payments to alternative payment models, such as ACOs, by the end of 2016, and tying 50 percent of such payments to alternative payment models by 2018. While the MSSP program has generated strong interest, sustained and increased participation hinges on the potential financial opportunities being adequate to support the investments needed to improve care and ultimately create a program that is sustainable for the long-term.

The AAMC and several other stakeholders, including physicians, hospitals, medical group practices, and nearly all existing MSSP ACOs, worked together on a set of joint letters that outline recommendations to improve the MSSP program. In this letter, the AAMC describes the specific impact of the key MSSP

proposals and policies to academic centers, the faculty practices and teaching hospitals, and the unique set of patients they serve. Those policies include:

- The continuation of a one-sided risk model in MSSP,
- The role of nurse practitioners and physician assistants in defining primary care, and
- The continued exclusion of policy add-on payments from ACO benchmarks and other financial calculations.

Below is a summary of these issues. A comprehensive discussion of each issue follows.

Continuation of a One-Sided Risk Model

The AAMC commends CMS for proposing to allow ACOs to continue in a one-sided risk model (Track One) beyond their first performance period. The Track One option for ACOs has been a powerful and attractive on-ramp for thousands of health care providers to begin to understand alternative payment models and to gain experience with population health management. Virtually all MSSP ACOs have selected this model to gain experience with the program.

The AAMC is disappointed, however, that CMS finds it necessary to penalize these organizations committed to delivery system reform by diminishing the business case for staying in Track One. The AAMC encourages CMS to modify its proposal and allow high-performing ACOs in Track One to continue in the program with the same, undiminished opportunity for shared savings. Further, given the bumpy start to the program for both participants and the Agency, the AAMC recommends that CMS establish a reconsideration process to ensure that ACOs are not excluded from ongoing Track One participation due to minor errors in initial data submissions or other reasonable foibles in the early days of the program.

Attribution through Nurse Practitioners and Physician Assistants

The AAMC recognizes and fully supports the crucial role of nurse practitioners (NPs) and physician assistants (PAs) in delivering primary care, and understands CMS's interest in including these primary care providers in the first step of ACO patient attribution to more fully capture the primary care services they provide to beneficiaries. We also note, however, that these providers are often members of *specialty* care teams, especially in AMCs and faculty group practices.

As AAMC has commented before, assuming all NPs and PAs are primary care providers has unintended consequences for institutions in which NPs and PAs care for complex and complicated patients. These effects are evident across multiple programs, not only MSSP. The AAMC has called for CMS to collect more robust data about the subspecialization of NPs and PAs before including them in the definition of primary care for the purposes of quality and cost measurement, and we welcome this opportunity to reiterate that recommendation. In the meantime, the AAMC suggests that for the purposes of MSSP patient attribution CMS require that NPs and PAs formally attest that they mainly deliver primary care in order to be included in an ACO's step one attribution.

Exclusion of Add-On Payments from Benchmarks

The AAMC continues to strongly support the policy adopted in CMS's Shared Savings Program finalized in September 2011: exclusion of IME and DSH payments from an ACO's financial calculations. This policy is necessary to protect beneficiary access to necessary care at teaching hospitals and is well within the bounds of CMS's statutory authority. To include these policy add-on payments in ACO benchmarks would give ACOs a strong financial incentive to focus on steering patients away from teaching hospitals and into settings that do not take on the missions of training the next generation of providers, caring for the underserved, and conducting research for the next healthcare innovations. Rather than reducing unnecessary hospitalizations through quality improvement and care coordination, ACOs would have the perverse incentive simply to game the system.

The AAMC appreciates CMS's reiteration of the Agency's well-reasoned argument for this policy in 2011, and supports CMS's decision to propose no changes to this aspect of the program.

Other Issues of Interest

Other recommendations from the AAMC include that CMS should:

- Offer all ACOs the option of prospective or retrospective patient attribution, rather than restricting prospective attribution only to the newly proposed "Track 3" option.
- Expand the waivers to ensure care improvement tools are available to all ACOs, or at least those meeting certain performance measures.
- Allow ACOs to divide tax identification numbers (TINs) for the purposes of ACO formation and risk track selection.
- Finalize the proposal to limit the administrative burden of requesting claims data on beneficiaries.
- Modify the risk adjustment methodology to allow an ACO's risk score to increase along with changes in patient complexity, rather than only decrease.
- Remove geographic outliers from an ACO's attribution, allowing ACOs to focus on coordinating care for those beneficiaries residing in their reasonable service area.
- Offer a two-year extension on existing contracts. Renewed participation agreements should be five years.

The remainder of this letter discusses in detail the recommendations outlined above.

PRINCIPLES FOR ALTERNATIVE PAYMENT MODELS

The AAMC's specific comments on MSSP have been developed through consultation with academic medical centers that participate in the MSSP and also reflect the Association's broader support for the design and implementation of alternative payment models in Medicare and Medicaid. Though many of these principles have been articulated to CMS in a variety of formal and informal settings, the AAMC outlines them here because of their central role in guiding our views on payment and delivery system reforms.

- *APMs Should Be Provider-Led and Promote the Role of Evidence-based Clinical Judgment*
The provider-patient relationship is central to high-quality and efficient health care. Only during an encounter between a clinician and a patient is it possible to fully assess the total array of complex conditions and factors contributing to the patient's condition. New APMs should support providers in these moments of clinical decision-making but not limit or impede them. The AAMC is encouraged by the creation of APMs that place providers, not third parties, at the center of both care management and risk management.
- *APMs Should Be Transparent, Predictable, and Given Sufficient Time to Succeed*
Providers choosing to participate in APMs should be able to trust that the rules of the program will be consistent and stable, that the methodologies for determining performance will be fully transparent and replicable, and that the program will allow sufficient opportunity to invest in change and reap the benefits of success.
- *APMs Should Not Risk or Diminish Policy Add-On Payments, Such As IME and DSH*
New payment models should enhance, or at least not jeopardize, the achievement of our shared goals – including providing community benefits consistent with the missions of academic medical centers, such as training new clinicians, caring for the underserved, emergency readiness, and groundbreaking research. Add-on payments such as IME and DSH that support these missions must be preserved, regardless of the payment model.
- *APMs Should Include Robust Risk Adjustment*
APMs should include robust risk adjustment that incorporates patients' clinical complexity and patient characteristics, including sociodemographic factors when appropriate. Providers participating in these new models should have every incentive to seek out complex patients with multiple comorbidities and social challenges to improve their care and outcomes, and the risk adjustment should align with this goal.
- *APMs Should Be Aligned with Other Quality-Measurement Programs and Reform Models*
New payment models should promote quality improvement and care redesign without adding undue burden on providers. Overlapping, duplicative, and inconsistent programs create unnecessary administrative inefficiency and detract from innovation and patient care. New and existing APMs should be aligned as fully as possible with other Agency quality-measurement programs and voluntary payment models.
- *APMs Should Be Diverse, to Meet the Needs of a Variety of Provider Types*
The AAMC supports CMS's approach to offering a variety of voluntary models, including those that allow advanced systems to take on more risk as they become ready.

COMMENTS ON PROPOSED CHANGES TO THE SHARED SAVINGS PROGRAM

Allow ACOs to Continue in a Viable One-Sided Risk Model

The AAMC commends CMS for proposing to allow ACOs to continue in a one-sided risk model (Track One) beyond their first performance periods. Finalizing a policy that enables ACOs to continue in a financially viable one-sided risk model is essential to the ongoing participation of dozens of ACOs in

MSSP. We are concerned, however, that CMS's proposal as written unfairly punishes organizations acting in good faith to invest in care coordination and quality improvement. Further, the policy does not recognize the investments these organizations have made to improve care and reduce costs. To diminish the portion of savings to be shared with these ACOs once hard-won success is achieved does little to encourage ongoing participation in APMs and will discourage additional organizations from joining. The AAMC urges CMS to continue Track One of MSSP as currently designed, without lowering the shared savings rate progressively over time.

The Track One option for ACOs has been an important and valuable introduction for thousands of health care providers to begin to understand alternative payment models and to gain experience with population health management. Nearly all of the Shared Savings Program ACOs led by academic medical centers participate in Track One, and many would have faced the unfortunate prospect of leaving the program if prematurely forced into taking downside risk. If CMS's current proposal is finalized, at least several will still face this difficult choice, by no fault of their own.

CMS proposed to limit Track One continuation to ACOs that meet certain quality benchmarks and that have not produced shared losses beyond the negative minimum savings rate (MSR) in either of the first two performance years. Some ACOs, including COTH members, have faced diminished savings – and in some cases losses beyond the negative MSR – because of initial glitches and misunderstandings in reporting of historic TINs in the first months of the program. These innocent errors, acknowledged but not remedied by CMS, will leave these ACOs unable to continue participation in the program. Presumably this type of early error is not a singular example. Rather than automatically forcing ACOs to choose between leaving the program or taking risk that they are not ready for, the AAMC recommends CMS establish a reconsideration process to which ACOs can apply to have their case reviewed individually. These ACOs should not be required to leave Track One due to administrative issues.

Require Nurse Practitioners and Physician Assistants to Attest to Primary Care for Purposes of Step One Assignment

CMS currently applies a two-step methodology to assign beneficiaries to ACOs. The first step is to identify the group that furnished the plurality of primary care services by primary care physicians. Any patient not assigned in the first step goes to the second step and is assigned based on the plurality of primary care services provided by all clinicians, including nurse practitioners (NP) and physician assistants (PA). CMS now proposes to move all NPs and PAs into step one of the assignment methodology. The AAMC acknowledges the important role of NPs and PAs in delivering primary care but is concerned about an Agency-wide, cross-program policy that assumes all NPs and PAs deliver primary care.

Moving all NPs and PAs to step one of the attribution methodology incorrectly assumes that all or most of these professionals provide primary care. However, data from the UHC-AAMC Faculty Practice Solution Center, which houses claims information from over 90 faculty practices, shows that at academic medical centers, on average, 63 percent of the services provided by these non-physician clinicians are for specialty care. Of those providing specialty care, the vast majority are billing under their own identifiers, not under the associated physicians'. Adding the non-physician clinicians to step one could inaccurately

assign some patients to a specialty team and away from their primary care team, if the two sets of providers participate in separate ACOs. Further, this policy has unintended consequences when adopted across other programs measuring quality and cost, including the Physician Quality Reporting System (PQRS) and the Value Modifier.

Rather than finalize the proposal, CMS should consider creating new specialty codes to distinguish which non-physician practitioners practice primary care and which practice specialty care. This data would allow CMS to more accurately measure whether care provided by NPs and PAs meets the test for step one ACO attribution applied to all other providers: primary care services provided by a primary care clinician. In the interim, CMS could consider establishing a policy that requires NPs and PAs participating in an ACO to affirmatively attest that they primarily deliver primary care services. Only those so attesting should be used for assignment purposes.

Offer Prospective Assignment to All ACOs

The AAMC supports CMS's introduction of prospective patient assignment into MSSP. As we previously commented in 2011, prospective assignment allows ACOs to create systems to actively manage and engage patients. Early understanding of its assigned beneficiaries allows an ACO to identify specific interventions and programs based on the characteristics and health status of its patient population. Prospective assignment would also allow ACOs the opportunity to review the patient list and ensure the accuracy of the assignment methodology. Though CMS has offered preliminary prospective assignment to support ACOs in achieving some of these aims, ACOs have experienced wide variance between their preliminary lists of patients and those for whom they were ultimately held accountable – making the preliminary lists of limited use.

Because the AAMC agrees with CMS's proposal to offer prospective assignment for the reason that it will improve patient care and ACO performance, the Association sees no reason to limit this option to only some ACOs. Every ACO allowed to participate in the Shared Savings Program should be given all reasonable opportunities to succeed – for the benefit of their patients, their participants, and the Medicare Trust Fund. Though CMS has a stated goal to incentivize ACOs to move into two-sided risk models, such an outcome should not come at the expense of opportunities to improve patient care. CMS has made other drastic proposals to make two-sided risk models more attractive; holding out on offering prospective attribution should not be one of them.

Offer Waivers of Key Medicare Policies to Support Care Coordination in All ACOs

The AAMC supports the Agency's proposal to support efficient and high quality care by promoting shorter hospital stays, regular use of telehealth technology, and home care services for those still able to function in their communities. Waivers of the three-day hospital stay requirement for skilled nursing facility care, post-acute care referrals, geographic requirements for reimbursement of telehealth consultations, and the homebound requirement for home health eligibility are all welcome additions to the Shared Savings Program that will improve patient care and reduce costs.

In designing these waivers, CMS should learn from the successes and challenges experienced in programs where some of these waivers have been piloted. As a facilitator-convener in the BPCI initiative, the AAMC recommends eliminating the short stay penalty when a patient is discharged to home health after a relatively short length of stay. Optimally CMS would promote short lengths of stay when medically appropriate, and increase the use of home health to avoid costly readmissions and emergency visits, rather than financially penalize providers for achieving these outcomes.

Further, the AAMC recommends that these important care coordination and clinical care tools be offered to all high-performing ACOs and not limited to those participating in a two-sided risk model. As demonstrated in previous CMS pilots and programs, and as expressed by CMS in the proposed rule, these waivers offer the opportunity for beneficiaries to experience improved outcomes, better experiences of care, and longevity in their homes. They also reduce costs for the Medicare Trust Fund, when implemented with organizations incentivized to curtail unnecessary utilization. For these reasons, the AAMC urges the Agency to offer these waivers to all ACOs. If the Agency is concerned about bad actors without accountability for downside risk, CMS could limit these waivers to both those ACOs in two-sided risk models *and* ACOs with at least one completed contract in Track One without violation of program parameters and with demonstrated quality improvement. For those ACOs with retrospective assignment, the Agency could limit the waivers to the preliminary prospective assignment list.

The AAMC appreciates that CMS wants to protect the Medicare program and encourage ACOs to move to two-sided risk; however, these waivers are important tools to help redesign care and improve savings and should be available to more ACOs.

Allow ACOs to Divide TINs for the Purposes of ACO Formation and Risk Track Selection

Currently, CMS regulations require that ACOs include all providers billing under a single tax identification number (TIN) if they wish to include any of the providers using that TIN. This has meant that organizations using a single TIN to cover a vast array of providers must choose to participate in the program with all of their providers, or none of them – a challenging proposition given that the decision to organize through a single TIN is rarely based on clinical integration or shared patient population factors that may guide the decision to form an ACO. The unit of organization required by CMS is too unrefined and leads many organizations to stay out of the program because it is daunting to take on risk for the full patient population that would be attributed to their TIN.

The AAMC is encouraged by CMS's partial acknowledgement of this issue in the proposed rule. The Agency introduces the idea of splitting a TIN for ACOs that want to start two-sided risk for a subset of their providers. This is a step in the right direction and indicates that CMS has overcome concerns about the administrative burden on the Agency if it were to conduct beneficiary assignment on the basis of National Provider Identifiers (NPIs). Given the Agency's willingness to consider to this method of assignment, the AAMC encourages CMS to allow ACOs to form on the basis of partial TINs. Doing so would allow large organizations such as academic medical centers and their faculty practice plans to enter the program with a subset of their providers – primary care providers, for example – rather than sitting out until they feel confident that the whole system was ready to participate.

Finalize Proposal to Reduce Burden of Requesting Beneficiary Data

Comprehensive and timely data is central to care coordination and population health management. Throughout the initial years of the Shared Savings Program ACOs have been challenged by the administrative requirements of obtaining historic and present-day data about their beneficiaries. The AAMC fully supports CMS's proposal to simplify the process for an ACO to request claims data about its assigned beneficiaries. CMS should finalize the proposal to allow ACOs to notify beneficiaries of their opportunity to opt out of data-sharing at points of care, rather than mailing onerous and often confusing letters to their patients. This new policy will have the benefit of reducing beneficiary confusion, speeding the delivery of essential care coordination data, and reducing the administrative costs of operating an ACO. Such improvements frequently have been recommended by academic medical center ACOs and others, and we are appreciative that CMS has responded positively to this feedback.

ADDITIONAL RECOMMENDATIONS FOR SHARED SAVINGS PROGRAM IMPROVEMENTS

Allow ACO Risk Scores to Increase to Reflect Actual Beneficiary Complexity

The current hierarchical condition category (HCC) risk adjustment methodology for ACOs allows for an ACO's risk score to decrease based on presumed health-improvement of its patients, but it prohibits an increase in the ACO's risk score based on continuously assigned beneficiaries becoming more complex or having their original complexity fully reflected in their claims over time. The current methodology, which only allows for patients to appear healthier but not sicker, requires vigilant ongoing coding of chronic conditions so as to prevent this decline in scores. Should an error be made, such as a failure to once again document a permanent condition such as an amputation, the ACO is forever disadvantaged because the risk score can never increase again.

This imbalanced risk adjustment methodology disadvantages all ACOs, but disproportionately affects ACOs led by academic medical centers. As has been well documented, AMCs treat sicker and more complex patient populations than most other providers. Their patients are more likely to have multiple comorbidities and thus to seek care from a greater number of providers. To properly capture their risk score through HCC-coding over a continuous number of performance years, a higher number of conditions must be accurately and repeatedly recorded by a larger number of providers, leading to a higher likelihood that — unlike healthier patients for whom little coding is necessary to reflect their risk — these complex patients will be 'under-coded'.

The AAMC previously commented that static risk scoring over the life of an ACO's participation agreement would create the incentive for ACOs to avoid taking on new complex patients. Though CMS has addressed this concern by allowing an ACO's risk score to increase based on newly-assigned beneficiaries, the problem still remains that complex and high-cost patients are under-addressed in the methodology if each of their conditions is not captured upon their first encounter. This is an unreasonable bar for most ACOs to meet.

CMS should alter its risk adjustment methodology to allow ACO risk scores to increase or decrease based on both newly assigned and continuously assigned beneficiaries to most accurately capture the true complexity – and therefore likely costs – of beneficiaries being served. If CMS is concerned about the possibility of inflated HCC scores, the AAMC encourages CMS to monitor ACOs for this behavior.

Exclude Geographically Distant Beneficiaries from ACO Attribution

The AAMC has heard from multiple members leading ACOs that a significant number of their attributed beneficiaries reside far from the ACO's general service areas. It is not atypical for academic medical centers to be destinations for specialized care, drawing patients from around the country and the world with specific and complex health care needs. Though these institutions provide high-quality care for these patients while within their walls, and prioritize well-coordinated discharges to their home communities, geographic distance makes ongoing care management relationships with these patients challenging. Data from ACOs led by academic medical centers reflects that these patients tend to be more complex and higher-cost than the average attributed beneficiary, and this is not surprising: the conditions that motivate patients to travel for care, such as transplants, are often complicated and costly. The ACO has little opportunity to make a meaningful difference in total cost of care or quality outcomes for these patients, because their local care providers are not integrated into data sharing or quality improvement initiatives. This dynamic disadvantages academic medical centers seeking to meaningfully improve quality and efficiency for their local communities of patients they regularly serve through the ACO model simply because of their additional mission of delivering ground-breaking specialized care.

To more fairly hold academic medical centers accountable for their ongoing patient population, the AAMC recommends that CMS exclude geographic outliers from ACO attribution. Such a policy could be defined by distance based on miles, out of state residence, or if one of these geographic factors is combined with attribution, on a limited number of attributing services billed over a short period of time.

Extend ACO Participation Agreements to Five Years

One of the AAMC's central principles for alternative payment models and delivery system reform is that providers making investments of time, resources, and expertise to improve quality and reduce cost should be given sufficient opportunity to achieve those goals and share in the savings they achieve for patients and the health care system.

To this end, the AAMC recommends that ACOs be offered a five-year participation agreement, instead of three years, to allow additional time to learn the nuances of the program, make care improvement investments, and learn from their initial experiences before having fledgling savings achievements recaptured into the baseline during the rebasing process. Such a change would both acknowledge the revolutionary investments of early adopters and encourage more institutions and organizations new to alternative payment models to participate, giving them more time to get off the ground and realize success.

REQUEST FOR COMMENTS: BENCHMARK CONSIDERATIONS

Though the Agency proposes no specific changes to the ACO benchmarking methodology, the proposed rule seeks comments on possible alternative methodologies and also technical adjustments to the types of payments and payment adjustments that should be included in ACO benchmark calculations. Given the complexity of the current benchmarking methodology, the many aspects of the program affected by any possible change, and the limited amount of performance data available, the AAMC appreciates CMS's cautious approach to seek comments and input from stakeholders, rather than make changes to this central programmatic feature so early in the program's tenure.

Because the Agency has not formally proposed any changes, and has not modeled the possible impacts of the alternatives on which it seeks comment, the AAMC expects that any future changes to the benchmarking methodology will be proposed through notice and comment rulemaking that provides more robust and detailed proposals than are in the current rule.

As a general concept, the AAMC supports changes that recognize an ACO's previous savings when updating the benchmark and provide the ACO with the ability to select the trending and risk options that make the most sense for its market. However, we agree with the Agency that it is premature to finalize any benchmarking methodology changes at this time.

CMS Should Continue to Exclude IME and DSH from Benchmark Calculations

The AAMC also appreciates that in seeking comment on technical changes, CMS reiterated the Agency's reasoning behind policy choices to which it remains committed; most notably, the exclusion of IME and DSH from ACO benchmark calculations. CMS wisely notes that "removing IME and DSH payments from benchmark and performance year expenditures would allow us to more accurately reward actual decreases in unnecessary utilization of healthcare services, rather than decreases arising from changes in referral patterns." The AAMC continues to wholeheartedly support this policy choice.

Because CMS has stated the Agency's intent to monitor the impact of this policy choice on the Shared Savings Program and seeks additional comments on this and other payment adjustments in benchmark calculations, the AAMC again voices our strongly held position that beneficiary access to care, Medicare's commitments to support the essential services that academic medical centers provide to communities consistent with their missions, and MSSP's aim to reduce unnecessary utilization are best served by excluding policy add-on payments from ACO financial incentives.

The Medicare program has long recognized the higher costs associated with the important societal roles of teaching hospitals and has provided DGME, IME, and DSH payments to help offset these costs. In addition to training future physicians and other health professionals, teaching hospitals treat the sickest and most complex Medicare patients. They have higher case mix indices (which measure the complexity and severity of a hospital's Medicare patients) and treat a disproportionate share of outlier cases (which reflects a high number of extraordinarily complex and severely ill patients). These institutions also receive the majority of transfers from other hospitals when patients need more sophisticated diagnostic

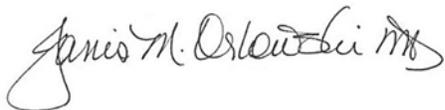
and treatment services than other providers can deliver and provide around-the-clock services in burn units, neonatal ICUs, and trauma centers.

Medicare provides IME, and DSH payments to help offset a portion of the costs related to these unique roles, and does so by increasing per-discharge reimbursement to the hospitals conducting these missions and incurring these costs. To include IME, and DSH payments in both the benchmark and performance expenditure calculations would create an economic incentive for physicians to admit patients to non-teaching hospitals, thereby potentially limiting access to medically necessary services. If the ACO's benchmark population previously utilized the services of teaching hospitals, the ACO could generate savings merely by directing patients to non-teaching hospitals while not truly reducing the utilization of services. Similarly, if an ACO's benchmark population were relatively healthy and did not previously require many teaching hospital admissions, an ACO would be incentivized not to send a patient to a teaching hospital during the performance period, even if the patient needed that level of care, because the higher payments would make it more difficult for an ACO to generate savings compared to its benchmark. Continuing to exclude IME, and DSH payments from the benchmark and performance calculations will help ensure that decisions by ACOs will be based on *clinical* determinations that are in the best interests of the patient and will not be influenced by financial interests.

CONCLUSION

If you have any questions concerning these comments, please feel welcome to contact Mary Wheatley, Director, Quality and Physician Payment Policies, at mwheatley@aamc.org or 202-262-6297.

Sincerely,



Janis M. Orlowski, MD, MACP
Chief Health Care Officer

cc: Ivy Baer, AAMC
Mary Wheatley, AAMC