



**Association of
American Medical Colleges**
655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399
T 202 828 0400
www.aamc.org

January 2, 2018

Submitted at: www.regulations.gov

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

Re: Medicare Program: CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year (CMS-5522-FC and CMS-5522-IFC)

Dear Administrator Verma:

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's or the Agency's) *Medicare Program*; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year, (82 Fed. Reg. 53568).

The AAMC is a not-for-profit association representing all 149 accredited U.S. and 17 accredited Canadian medical schools; over 400 major teaching hospitals and health systems, and more than 80 academic and professional societies. Through these institutions and organizations, the AAMC represents 167,000 faculty members, 88,000 medical students, and 124,000 resident physicians. In academic medical centers, faculty physicians frequently are organized under a single tax identification number (TIN) and treat the most vulnerable patients, those individuals who are poor, sick, and have complex medical needs.

The AAMC commends CMS for working to reduce burden while promoting quality. We appreciate that CMS continues to listen to the concerns of physicians and other stakeholders regarding the framework of the new physician payment system required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). While the final rule includes some improvements, the AAMC still has concerns with some of the components of the quality payment program (QPP) provisions, which we discuss in this comment letter.

We are committed to working with CMS to ensure that MACRA promotes improvements in delivery of care and is not overly burdensome to clinicians and the organizations for which they work. The following highlights the AAMC's principal recommendations to CMS for both the Merit-Based Incentive Program (MIPS) and Alternative Payment Models (APMs) for future years.

- ***Risk Adjustment:*** Risk adjust outcomes, population based measures, and cost measures for clinical complexity and sociodemographic (SDS) factors should be considered for all measures and utilized where appropriate.
- ***MIPS Identifiers:*** In addition to using the TINs, NPIs, and APM identifiers, create an option for a MIPS identifier that would allow large multi-specialty groups to have sub-groups under the same TIN assessed in the quality payment programs in a way that is meaningful.
- ***Cost Category:*** Maintain the cost category performance weight at zero and urge Congress to remove the mandate that the cost category be weighted at 30 percent in performance year 2019. Prior to implementation, address risk adjustment and attribution concerns related to the cost measures.
- ***Improvement Activities:*** CMS should consider future expansion of new improvement activities related to teaching.
- ***Extreme and Uncontrollable Circumstances Policy:*** Finalize the extreme and uncontrollable circumstances policy for 2017 and 2018 MIPS performance years and apply it uniformly under the QPP program so that group practices are also included.
- ***Nominal Financial Risk Definition:*** Extend the revenue based nominal amount standard of 8 percent beyond 2020 to preserve stability in the program. Eliminate the 50 clinician cap on medical homes.
- ***Other Payer Advanced APMs:*** Allow determinations of other payer advanced APMs to remain in effect for at least 3 years if there are no material changes in the A-APMs.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

CMS should risk adjust measures in MIPS as appropriate for clinical complexity and sociodemographic factors.

In the MIPS program, CMS has implemented numerous measures for the four performance categories: quality, cost, performance improvement activities, and advancing care information. The AAMC is supportive of measures that are meaningful to providers and consumers, and lead to quality improvement. However, it is essential that CMS ensure that measures used in the

program are valid and reliable, risk adjusted as appropriate, and do not lead to unintended consequences. We remain concerned that outcome measures, cost measures, and population based measures are not appropriately risk adjusted for clinical complexity and sociodemographic factors. Physicians at academic medical centers (AMCs) care for a vulnerable population of patients who are sicker, poorer, and more complex than many patients treated elsewhere.

Recent reports from the National Academies of Science, Engineering and Medicine and Assistant Secretary for Planning and Evaluation (ASPE) have clearly acknowledged that SDS variables (such as low income and education) may explain adverse outcomes and higher costs. Without accounting for these factors, the scores of physicians that treat vulnerable patients will be negatively and unfairly impacted and their performance will not be adequately represented to patients. Differences in patient severity, rates of patient compliance with treatment, SDS, patient engagement, patient preferences for treatment approaches, and sites of care, can all drive differences in average costs.

Appropriate risk adjustment is essential so that differences in patient characteristics that are beyond a health care provider's control do not have an unfair impact on a provider's resource use performance score. The AAMC believes that CMS should appropriately adjust for SDS by incorporating identified factors into the risk adjustment methodology. As more is learned further refinements can be made in the future.

Develop a MIPS Eligible Identifier for subgroups in multi-specialty practices.

CMS recognizes multiple identifiers that allow MIPS eligible clinicians to be measured as an individual or through a group's performance. CMS acknowledges that groups, including multi-specialty groups, have requested an option that would allow a portion of a group to report as a separate subgroup on measures and activities that are more applicable to the subgroup and be assessed based on performance of that sub-group. CMS asks for more feedback in the final rule on these sub-groups and additional ways to define a group, not solely based on TIN.

The AAMC encourages CMS to add a distinct subgroup identifier under MIPS, similar to the identifiers used for virtual groups or for Advanced Payment Models that would allow a subset of physicians within a large multi-specialty TIN to form their own subgroup that could be assessed under MIPS.

This would allow for more accurate and meaningful measurement under the program. To allow participation in MIPS at a sub-group level, the AAMC recommends that CMS follow some of the policies set forth for virtual groups, which include:

- Establish a subgroup identifier
- Require the subgroup to make an election prior to the start of the applicable performance period under MIPS to be a subgroup.
- Request that a list of participants who would be part of the subgroup identifier be provided to CMS. A subgroup would submit each TIN and NPI associated with the subgroup, the name and contact information for a subgroup representative and a confirmation that each member of the subgroup is aware of their participation.

- Each MIPS eligible clinician who is part of the subgroup could be identified by a unique subgroup participant identifier which would be a combination of the subgroup identifier (established by CMS); 2) TIN and 3) NPI.
- Assess performance by a method that combines performance of all MIPS eligible clinicians in the subgroup across all four performance categories.

Depending on the practice, there are advantages and disadvantages to reporting under a subgroup MIPS identifier, an NPI, a TIN, or a combination. Under the MIPS program, the practices should be given the opportunity to assess the advantages and disadvantages and select whichever option works best. These groups should continue to make their own decision regarding the reporting option under MIPS. The AAMC would welcome the opportunity to work with CMS to ensure that this option is structured in a way that is not overly complex and would offer a more meaningful reporting option for certain physicians that are part of multispecialty groups.

Cost Performance Category

CMS should maintain the cost category at zero percent.

In the 2018 proposed rule, CMS proposed maintaining a weight of 0 percent for the cost category in 2018. However, in the final rule, CMS finalizes a weight of 10 percent for the 2018 MIPS performance year for the cost performance category in the MIPS final score. Starting with 2021 MIPS payment year, the cost performance category will be weighted at 30 percent.

CMS plans to assess performance in the cost category by utilizing: 1) the Total Per Capita Measure and 2) the MSPB measure. CMS finalizes its proposal not to include the 10 episode-based measures it adopted in the 2017 performance period. Instead, CMS will continue to work on the development and outreach for new episode measures, which CMS began field testing in October 2017. CMS intends to provide feedback on the new measures in the summer of 2018 to those MIPS clinicians for whom it can calculate episode-based measures.

The AAMC supported the proposal by CMS to maintain the weight of zero for the cost category for the second year of the program and therefore was disappointed to see the weight finalized at 10 percent. **Given the multiple undetermined factors under the cost category, including the need for risk adjustment, the need for better attribution methodologies, and further development of episode groups, the AAMC supports the continued weight of this category at zero.** Further, the AAMC encourages CMS to work with Congress to remove the mandate that the cost category be weighted at 30 percent in performance year 2019.

All cost measures must be appropriately adjusted for clinical severity and sociodemographic (SDS) factors

In the rule, CMS notes that the total per capita cost measure and the Medicare Spend Per Beneficiary (MSPB) measure are risk adjusted to recognize the higher risk associated with demographic factors, such as age, or certain clinical conditions. CMS acknowledges that concerns were raised about the need to adjust for other factors such as income level and race and states they may consider these factors as part of future rulemaking.

Physicians and other providers at AMCs care for a vulnerable population of patients who are sicker, poorer, and more complex than many patients treated elsewhere. These factors generally mean that patients will require higher resource utilization. **AAMC remains concerned that the risk adjustment models for the cost measures (total per capita cost and MSPB) do not adequately address the impact of sociodemographic factors and request that additional factors (race and income level) be added now and that in the future other factors be added, with continuing refinement of all factors as better data becomes available.**

Reliable, Valid Cost Measures Depend on Accurate Attribution

In addition, reliable and valid cost measures depend heavily on ensuring there is accurate attribution of patients to providers. MACRA requires that CMS develop codes that describe the various types of relationships between patients and providers to allow accurate attribution of patients to the appropriate providers. CMS proposed in the 2018 physician fee schedule rule to implement the reporting of the relationship modifiers on the claims forms on a voluntary basis beginning January 1, 2018. It will take time to gather accurate information from reporting of these modifiers and to determine whether it can be used for attribution. Therefore cost should not be zeroed until these attribution methods are complete.

Improvement Activities (IA) Performance Category

The AAMC strongly supports the inclusion of the following new improvement activities listed in Table F of the rule:

- MIPS eligible clinicians acting as preceptor for clinicians-in-training (such as medical students, physician assistants, nurse practitioners, or clinical nurse specialists) and accepting such clinicians for clinical rotations in community practices in small, underserved or rural areas. (Activity ID: IA_AHE_XX)
- Participation in federally and/or privately funded research that identifies interventions, tools, or processes that can improve a targeted patient population. (IA_PM-XX)
- Clinician Leadership in clinical trials, research alliances or community-based participatory research (CPBR) focusing on minimizing disparities in healthcare access, care quality, affordability, or outcomes. (Activity ID: IA_AHE_XX)
- Completion of an Accredited Safety or Quality Improvement Program that addresses performance or quality improvement according to certain criteria. (IA-PSPA_XX)

The AAMC appreciates CMS' recognition of the importance of eligible clinicians acting as preceptors for clinicians-in-training. The improvement activity could assist in the acceptance of a clinician-in-training in community practices where they can obtain experience working in underserved, rural areas and provide additional support in these communities. We urge CMS to consider expanding this improvement activity to include medical school faculty physicians and teachers of other health care professionals and to be expanded beyond rural areas. At a minimum, any underserved area should count. These faculty physicians and teachers of other health care professionals regularly engage with students, residents, and other allied health professionals to ensure that their education includes knowledge about improving quality of care,

safety, and patient outcomes. Teaching in accredited programs assures a well-prepared and qualified workforce providing health care services, thereby improving patient care. The teaching, which includes treating the diverse populations that receive care in academic centers, promotes health equity. We recommend that the program and institution where the physicians and other health care professionals teach must be accredited to ensure that it is a sound institution and meets certain minimum standards in terms of administration, resources, faculty and facilities. This will provide for a better prepared health care workforce with the skills needed to provide high quality care.

CMS' should extend bonus points for MIPS eligible clinicians who care for complex patients beyond 2018 and increase the cap

In the final rule, CMS establishes a complex patient bonus of up to 5 points (an increase from the 3 proposed) for eligible clinicians who care for complex patients. We applaud CMS for recognizing the need to provide a bonus for treating complex patients. Physicians at AMCs care for vulnerable populations of patients who are sicker, poorer, and more complex than many patients treated elsewhere. As a result, they may require higher resource utilization, which may impact their quality scores. We urge CMS to extend the bonus beyond the 2018 performance year and to potentially increase the cap so that it is higher than 5 points. The impact of the bonus on the final score, even when increased to five points (out of 100), may be minimal.

In the final rule, CMS pairs the average HCC risk score with the proportion of dual eligible to determine the complex patient indicator. We believe that this is a first step towards identifying complex patients; however, we recommend CMS consider and test additional variables when accounting for social risk factors for purposes of determining a bonus for treating complex patients. CMS should consider the four domains recommended by the National Academy of Medicine, which include: (1) income, education and dual liability; (2) race ethnicity, language, and nativity; (3) marital/partnership status and living alone; and (4) neighborhood deprivation, urbanicity and housing.

CMS should finalize its extreme and uncontrollable circumstances policy for 2017 and 2018 MIPS performance years and apply uniformly under the QPP program.

In the CY 2017 QPP final rule, CMS established a policy allowing a MIPS eligible clinician affected by extreme and uncontrollable circumstances (e.g. natural disaster) to submit an application to CMS to be considered for reweighting the AI performance category. In this rule, CMS finalizes a policy that beginning in the 2018 performance period would allow for reweighting of the quality, cost, and improvement activities performance category based on extreme and uncontrollable circumstances if a request is submitted. This policy does not apply to APM Entities. We support this policy as eligible clinicians affected by these events are already significantly burdened and should not be subject to MIPS requirements.

For those affected by the recent hurricanes Harvey, Irma, and Maria, CMS adopts interim final policies for the 2017 performance period (2019 payment year) that would enable eligible clinicians to be exempt from MIPS reporting due to certain triggering events. These clinicians would not need to apply in order to obtain MIPS exemptions. Groups are not included in the

automatic extreme and uncontrollable circumstances policy. **AAMC strongly supports this policy as it will reduce clinician burden during times of extreme circumstances, such as national disasters. However, we recommend CMS apply this policy not only to individual clinicians but also to groups that are in the affected areas.**

ADVANCED ALTERNATIVE PAYMENT MODELS

The AAMC encourages CMS to continue to allow more opportunities for physicians to be qualified APM participants and receive the 5% incentive payments. The AAMC supports alternative payment model (APM) programs, such as accountable care organizations (ACOs) and bundled payment initiatives, that seek to promote high-quality, efficient care while retaining at their core the essential patient-physician relationship. Many AAMCs are participating in new payment models, including Pioneer ACOs and Medicare Shared Savings Program (MSSP) ACOs, and BPCI. The AAMC strongly supports the work of our members, as is evident from our role as a facilitator-convenor for the Bundled Payments for Care Improvement (BPCI) initiative for 30 hospitals and 19 health systems. Our own and our members' experiences with such alternative delivery models largely inform our comments below.

Nominal Amount Standards for Advanced APMs

Eliminate the 50 Clinician Cap on Medical Homes

MACRA requires that an Advanced APM must be either a Medical Home model expanded under section 1115A(c) or bear financial risk in excess of a nominal amount. CMS applies a nominal amount standard for medical home models that is different from the Generally Applicable Nominal Amount Standard. CMS states that beginning in 2018 the medical home model must have 50 or fewer eligible clinicians in the organization to meet this criteria. CMS would use the count of eligible clinicians in the parent organization of the APM entity as the metric for organizational size for medical home models. CMS exempts from this requirement those entities enrolled in Round 1 of the Comprehensive Primary Care Plus (CPC+) model since the size requirement was finalized after CPC+ participants signed agreements with CMS. However, future CPC+ participants would not be exempt.

The AAMC commends CMS for exempting the Round 1 CPC + participants. However, the AAMC continues to oppose requiring medical homes with more than 50 clinicians to meet a different set of financial requirements in 2018. The 50 clinician limit is entirely arbitrary and excludes the very groups that may be best resourced and equipped to deliver PCMH services. Such a limit would particularly hinder access to PCMH services in underserved communities, where large faculty practice plans are some of the only providers offering coordinately, culturally appropriate care. Excluding these medical homes simply for their size will discourage large groups from seeking this designation. Therefore, CMS should eliminate the 50-clinician cap on medical homes eligible for this standard from going into effect in 2018.

Generally Applicable Revenue-Based Nominal Amount Standard

The AAMC supports CMS' decision that the generally applicable revenue-based nominal amount standard remains at 8 percent of the average estimated total Medicare Parts A and B revenue of providers participating in APM entities for the 2019 and 2020 Medicare QP performance periods. To preserve stability and clarity in the program we believe it is important to maintain the standard at 8 percent beyond 2020, and recommend the extension for the next 3 years at a minimum.

The current levels of risk are more than sufficient to promote accountability. In addition, eligible clinicians will already be taking on additional risk in advanced APMs as the thresholds to be a qualified participant in an Advanced APM increase from 25% of Medicare payments to 75% of Medicare payments, and the patient count threshold increases from 20% of patients to 50% of patients over the next several years. CMS should review and analyze information about physician participation in advanced APMs over the next few years to determine whether a change in the amount of required financial risk should be made in the future. If CMS sets a downside risk that is too high, it will create a barrier to physician participation.

We recommend that CMS exclude Part B drug revenues from the calculation of the revenue based standard amount. The majority of the time, payments for these drugs are treated as pass through payments to cover the cost of acquiring the drug. For some physicians, such as oncologists, the revenues and costs for these drugs are significantly higher than the revenues used to pay for physician's professional services, thereby placing the practice at high risk of losing most of their revenues derived from professional services.

Other Payer Advanced APMs

Financial Risk Standards

CMS adds a revenue-based nominal amount standard to the generally applicable nominal amount standard for Other Payer Advanced APMs that is parallel to the standard for the Medicare Advanced APMs. Specifically, the Agency states that the standard would be met if the total amount that an APM entity owes the payer or forgoes is 8 percent of the total combined revenues from the payer of providers in participating APM entities. However, CMS also requires that the other payer advanced APMs meet requirements related to marginal risk and the minimum loss rate.

While we support the addition of the revenue based standards, we urge CMS to align the Advanced APM criteria by making the Other Payer Advanced APM nominal amount standard consistent with the Medicare Optional nominal amount standard. This would expand opportunities for other payer arrangements to qualify as Advanced APMs and help to facilitate physician involvement in other payer models. It is difficult for physicians to stay abreast of different requirements regarding payment structures, quality metrics, and other components of these programs.

Other Payer Advanced Determination Process

Starting in 2021, a clinician may achieve Qualified Participant(QP) status through the All-Payer Combination Option. Thresholds under this option can be met by combining payments or patients from Other Payer Advanced APMs with those from Medicare Advanced APMs. To be considered an Other Payer Advanced APM, the APM must meet criteria for CEHRT use, MIPS-comparable quality measures, and financial risk.

CMS finalizes its proposal to begin the first year of the Other Payer Advanced APM determinations with an annual submission and determination process. CMS establishes processes by which either the payer or the eligible clinician submit detailed information to CMS regarding the arrangement to determine whether the Advanced APM criteria are met.

The AAMC has significant concerns with the approach to the All Payer Combination Option. It presents major operational challenges for eligible clinicians who have to provide this detailed information each year. Reporting the information to CMS would be extremely burdensome for the eligible clinicians and there also could be constraints in their contractual arrangements with the payer that limit their ability to share some of the information.

An annual application process further increases the burden on clinicians, payers, and CMS staff with little benefit. If there are no material changes to a model, there should be no need to resubmit the application each year. CMS should allow these determinations to remain in effect for at least 3 years if there are not material changes to minimize the administrative burden and to provide stability to the physician practices that devote significant resources to participation in the Advanced APM. CMS could develop a simple attestation process, with only information necessary to verify that there are no changes since the prior determination to minimize burden.

Under CMS' policy, in 2019 the payer initiated process is only available for Medicaid, Medicare Advantage, and CMS multi-payer models. In the future, CMS plans to add other payers. We encourage CMS to add private payers to the group if they are willing to supply CMS with the data it needs to complete its determination. Waiting until 2020 or later may be disappointing to physician practices that engaged in arrangements with private payers to take on financial risk by participating in APMs.

CMS Should Take Steps so that it is More Feasible to Achieve the Qualifying APM Threshold

CMS sets forth the threshold requirements for qualifying and partial qualifying APMs using payment or patients. Initially, the threshold will be 25% for payments and 20% for patients, and will increase to 75% in 2023. CMS also established the method for threshold calculations in the final rule. CMS states that the numerator will be the aggregate of all covered Part B professional services furnished by an Advanced APM Entity's eligible clinicians to attributed beneficiaries during the QP Performance period. The denominator will be the aggregate of all payments for Medicare Part B covered professional services furnished by an Advanced APM entities eligible clinicians to attribution-eligible beneficiaries during the QP performance period.

The AAMC continues to have concerns with the threshold calculations. We recommend that CMS limit the threshold calculations to those beneficiaries that live within the APM entity's

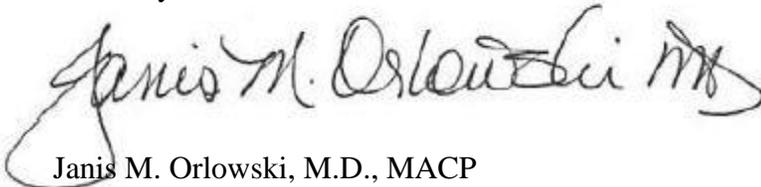
primary service area. Even the most motivated academic medical center seeking to draw all of its community's Medicare beneficiaries into APM alignment will continue to see many patients who travel great distances to access specialty care. These cases are often complex and expensive, and may balloon an APM entity's threshold denominator, leaving no possibility of ever being able to attribute such patients to the numerator. Already, CMS has excluded such patients from the financial reconciliation calculations of some APMs. They should be similarly excluded from the threshold calculation.

While it may be feasible to meet the 25% threshold of Medicare payments, the 75% threshold in the future will be very challenging and few eligible clinicians may be able to meet it. We recognize that this threshold is set in statute and encourage CMS to work with stakeholders to monitor this potential problem so that real data can be provided to Congress for the purpose of considering legislative relief in the future.

CONCLUSION

Thank you for your consideration of these comments. If you have any questions concerning these comments, please feel welcome to contact Gayle Lee, Director of Physician Payment Policy and Quality at 202-741-6429 or galee@aamc.org, or Kate Ogden, Physician Payment and Quality Specialist at 202-540-5413 or kogden@aamc.org.

Sincerely,



Janis M. Orłowski, M.D., MACP
Chief, Health Care Affairs, AAMC

Cc:

Ivy Baer, AAMC
Gayle Lee, AAMC
Kate Ogden, AAMC