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Via Electronic Submission (www.regulations.gov)

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Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
ATTN: CMS-5519-P
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR), File Code CMS-5519-P

Dear Acting Administrator Slavitt:

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) proposed rule entitled, *Medicare Program, Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR), Proposed Rule*, 81 FR 50793 (August 2, 2016). The AAMC is a not-for-profit association representing all 145 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, and 80 academic and scientific societies. Through these institutions and organizations, the AAMC represents 160,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

As a facilitator convener under the Bundled Payments for Care Improvement (BPCI) initiative, we have a deep interest in the promise of bundled payments to create the right incentives for the provision of high-quality, efficient care. Between our BPCI, Comprehensive Care for Joint Replacement (CJR) and Oncology Care Model (OCM) collaboratives, we actively support over 40 hospitals' bundled payment program implementation efforts. The lessons garnered from this experience heavily inform the content of this comment letter.

AAMC commends CMS for creating new opportunities for providers to engage in alternative payment models, and for giving great consideration to designing a program that reflects the clinical and financial realities of these conditions. At the same time, the Agency's proposal raises important questions about the design of a mandatory program for hospitals of many different sizes and types, and at very different points in the "re-design" process. AAMC believes that many aspects of the proposed program must be altered to ensure that hospitals that invest in care

interventions have a fair opportunity to realize savings under EPMs. Specifically, the AAMC strongly urges CMS to make the following changes:

- Extend the no downside risk period to include a full calendar year;
- Amend the chained anchor hospitalization proposal to grant the second and final hospital financial ownership of the EPM episode;
- Change the quality performance requirements to ensure program success and standardize quality of care; and
- Ensure that participation in future bundled payment programs is voluntary.

EXTEND NO DOWNSIDE RISK PERIOD

CMS proposes that EPM participants would not face downside risk during performance year (PY) 1 and the first quarter (Q1) of PY 2 (ending March 31, 2018). Due to the fact that episodes are attributed to the quarter in which they end, this proposal would effectively grant participants only six months of no downside risk, as the timeframe would only include episodes with patients that are discharged by December 31, 2017. AAMC firmly recommends that the no downside risk period be extended to Q3 of PY 2 (ending September 30, 2018), such that EPM participants would have a full calendar year of no downside risk.

Many hospitals that are ultimately selected for EPMs will have no prior experience operating under risk-based models. Furthermore, hospitals will not know if they are required to participate in the Coronary Artery Bypass Grafting (CABG) or Acute Myocardial Infarction (AMI) EPMs until the final rule is released. In order to appropriately direct the resources to thoughtfully implement a bundled payment program, hospital administrative and clinical staff must undertake many activities, including but not limited to the following:

- Learn EPM program rules and policies;
- Understand the mechanics of bundled payment;
- Review Medicare claims data to identify risks and opportunities and expertly target customized care interventions;
- Educate and engage clinical staff;
- Inform and educate Medicare beneficiaries;
- Develop and execute new contracts with physicians and all providers that address gainsharing;
- Identify and contract with key post-acute care (PAC) partners;
- Develop specific EPM care pathways and quality metric tracking systems in electronic medical records (EMRs); and
- Create accounts and financial systems to track reconciliation and gainsharing payments.

AMCs' experiences in CJR also support the need for an extended upside-only period. There is no downside risk during PY 1 of CJR. PY 1 is defined as episodes that start on or after April 1, 2016, and end on or before December 31, 2016. This definition effectively limits the upside-only phase of CJR to six months, as a 90-day episode must start by September 30, 2016 in order to end by December 31, 2016. Episodes that start in October 2016 and beyond would fall into performance

year 2. As of September 2016, CJR participants have yet to receive any data for completed performance period episodes. Data received to date only includes incomplete episodes that started in April 2016. AAMC acknowledges that the dearth of complete data is due to claims lag and is not the fault of CMS. However, hospitals need performance period data in order to design strategic care interventions. While baseline data is also key to this process, BPCI demonstrated that clinical and financial metrics can change dramatically from baseline to the performance period. Providers that predicate their implementation strategy solely on baseline data run a risk of misdirecting their resources.

AAMC acknowledges that some practices may wish to accept financial risk sooner in order to qualify as an Advanced APM. While we ultimately believe that CMS should extend the upside-only period of EPMS, CMS could consider giving participants the option to elect to accept downside risk phase at an earlier point.

RECOMMENDED REFINEMENTS TO THE BPCI MODEL

AAMC appreciates that CMS intends to design a new voluntary bundled payment model for CY 2018 that is designed to meet the Advanced APM criteria. We believe that many of the eligible clinicians participating in BPCI are in fact using CEHRT in a manner that meets the requirements outlined in the Quality Payment Program proposed rule. In a new model, CMS should implement a measure assessing the use of CEHRT within BPCI similar to the measure proposed for MSSP in the QPP proposed rule.

Above all, we believe it is crucial that participation in future bundled payment models indeed be voluntary, and that future models be designed in such a manner as to enable successful participation by any and all interested hospitals. In addition, performance period data should continue to be provided on a monthly basis, with quarterly reconciliation reports. The next iteration of BPCI should feature program elements that characterize CJR and EPMS, such as:

- Caps on total losses that start small and gradually increase over time;
- Variable discounts that are based on a quality composite score; and
- Elimination of financial responsibility for payments above a threshold on an individual-episode basis.

Most importantly, hospitals currently participating in BPCI should be allowed to test additional episodes, and new hospitals should be allowed to enter the program.

SUPPORT DEFINING TRACK 1 OPTION AS AN ADVANCED APM

In the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) proposed rule, CMS did not propose to include CJR as an Advanced APM that would be considered when determining the eligibility of clinicians for the 5 percent incentive payment citing the fact that the model does not incorporate a Certified Electronic Health Record Technology (CEHRT) requirement. In this rule, CMS proposes that both the EPM and CJR providers that attest to the adoption of CEHRT could become a qualified participant (QP) under an Advanced APM if they choose “Track 1.” Those that do not voluntarily participate in Track 1 would be in “Track 2.”

The AAMC appreciates that CMS is responding to numerous commenters to the MACRA proposed rule, requesting that CMS alter the CJR program to allow it to qualify for Advanced APM status. We further support the intentional inclusion of design parameters allowing the EPM models to meet the Advanced APM criteria as soon as the providers bear risk. AAMC recommends that CMS clarify that the CEHRT requirement only apply to hospitals, not to other entities that provide care to patients during the post-discharge period such as skilled nursing facilities (SNFs). In addition, we support CMS's plans to recognize clinicians who participate in APMs as affiliated practitioners. CMS should ensure that there is minimum burden when providing participant lists and enable more frequent updates to the participant list. Furthermore, the AAMC encourages CMS to consider using claims data to identify APM participants instead of relying solely on a participant list.

The Association believes the addition of episode-based models fills a void in the Advanced APM models that will assist specialists in reaching the required thresholds to obtain QP status. However, we urge CMS to make these changes for CJR in 2017 rather than waiting for 2018. The agency already has a process through the Meaningful Use program to gather the attestations from the hospitals and should be able to use this existing process and information. Furthermore, we encourage CMS to enable providers to shift from Track 2 to Track 1 with relative ease, and to clarify that the BPCI, CJR, and EPM models are MIPS APMs for which special scoring rules apply. Finally, we believe calling the more advanced risk-bearing model Track 1 will be confusing given that the higher number tracks in MSSP are more advanced and bear greater risk. CMS should consider flipping the nomenclature or identifying an alternative naming convention.

While this proposal provides a welcome opportunity for most hospitals, we note that rural hospitals, sole community hospitals (SCHs), Medicare Dependent Hospitals (MDHs) and Rural Referral Centers (RRCs) would not potentially qualify as an Advanced APM until performance year 3 due to the stop loss limits. AAMC agrees that more conservative stop loss limits are appropriate for these facilities, but does not believe these limits should preclude qualifying as an Advanced APM. As the Association commented in our letter on the proposed rule to implement MACRA, CMS should lower the nominal risk requirements for Advanced APMs under MACRA.

EPISODE DEFINITION FOR EPMs

AAMC supports the CMS proposal to use many of the same BPCI Model 2 and CJR episode parameters to define EPM episodes.

Support AMI EPM Episode Definition

Under EPMs, an AMI episode would be triggered by an index admission for AMI MS-DRGs 280-282 or percutaneous coronary intervention (PCI) MS-DRGs 246-251 with a principal or secondary diagnosis of AMI. In effect, this proposal would combine the AMI episode family and part of the PCI episode family as defined under BPCI. AAMC believes this definition is clinically appropriate, as AMI is a condition that can require a range of treatments, including both medical treatments and a PCI. In addition, the combination of these episode families into a single AMI

EPM episode is likely to present EPM participant hospitals with greater opportunity than if the hospital managed just one of these DRG groupings. For one, the proposed definition will increase providers' EPM episode volume. Sufficient volume is key in any bundled payment program to ensure that financial results are not primarily driven by random variation.

90 Days is the Appropriate Episode Duration

AAMC believes that 90 days is the most clinically appropriate length for a bundled payment episode and enhances the commitment to caring for patients over time. This duration is sufficiently long to capture many complications and engage multiple providers in inpatient, outpatient, and post-acute care settings. This duration also moves providers closer to achieving long-term population health management.

Inpatient-to-inpatient Transfer Episodes Should be Attributed to the i-i Transfer Hospital

CMS proposed that if a patient presents to one hospital's emergency department (ED), and is not admitted but instead transferred to a second hospital, the second hospital would own the episode. Conversely, CMS proposed that in the event a patient is admitted to an initial treating hospital under an AMI or CABG EPM DRG and is later transferred to a transfer hospital (i-i transfer hospital) the episode would be attributed to the initial treating hospital. While AAMC acknowledges the validity of certain arguments that underpin this proposal, we ultimately believe it is more appropriate for the i-i transfer hospital to retain financial responsibility for the episode.

We are concerned that attributing the episode to the initial treating hospital could create perverse incentives regarding patient care. The main priority of AAMC and our members is that patients have access to the right place for care. Bestowing financial ownership to the initial treating hospital could encourage the hospital to do one of two things: 1) Immediately transfer patients that present at the ED with AMI symptoms; or 2) Not transfer patients at all, or not transfer patients to hospitals within the MSA.

CMS partially predicated their proposal on the fact that patients like to receive follow up care in their community, and astutely noted that many CJR beneficiaries that require post-acute care prefer to return to their home communities for that care following hospital discharge. However, major joint replacement is an elective procedure for most patients, thus affording more patients the opportunity to plan out the procedure in advance and travel farther for the surgery. Meanwhile, AMI and CABG EPM patients are much more likely to require emergent care, and have less of an opportunity to seek care from a facility located outside of their region. Indeed, CMS's own analyses support this fact:

“About 75 percent of historical AMI episodes and CABG episodes for beneficiaries with AMI begin through the emergency department of the hospital where the anchor hospitalization for the AMI or CABG model episode would occur. In another 18 percent of historical AMI episodes and CABG episodes for beneficiaries with AMI, the anchor hospitalization occurs at a transfer hospital following an emergency department visit at

another hospital without admission to that hospital for an MS-DRG that would initiate an AMI or CABG model episode.” (81 FR 50836).

AMI and CABG EPM patients are far less likely to travel far for their care than CJR patients. As a result, many patients will remain in the same region as the i-i transfer hospital for post-acute care.

We note that if our proposal is adopted, all care provided at the initial treating hospital should be excluded from the episode. In addition, we encourage CMS to monitor the relative cost of episodes that start with a transfer versus those that do not. Depending on the results, it may be appropriate to apply an additional adjustment to the target price of such episodes.

EPM EPISODE PRICES

The Timeline for 100% Regional Pricing is Too Aggressive

AAMC has concerns regarding the CMS proposal to incorporate regional data into EPM target prices. As proposed, 100% of an EPM’s target price would be based on regional data by performance year 4. Many hospitals in the 98 MSAs do not have adequate time to implement a bundled payment program, let alone be subject to regional pricing. However, AAMC recognizes that a subset of high volume AMCs may perform well under regional pricing. These AMCs have realized economies of scale by performing a large volume of procedures and have been able to deploy intensive improvement strategies for many years. These efficient providers will thrive under a regional model. AAMC recommends that CMS adopt a target price methodology that assigns a hospital a target price that is the higher of the hospital-specific methodology or the proposed blended hospital-specific/regional methodology.

AAMC also notes that while a blend of historical and regional pricing may present a tenable pricing model for elective conditions for some institutions, such a model could create serious issues if applied to medical conditions such as coronary artery disease (CAD). Episode payments for such conditions vary drastically both within and between different providers’ patient populations. It is incumbent upon the Agency to study regional pricing methodologies, broadly disseminate the findings, and utilize those methodologies that are less likely to penalize both efficient providers and those that may be high cost in their regions due to factors that they cannot reasonably control, such as patient risks and the provision of quaternary services.

Regional pricing also presents concerns in the absence of robust risk adjustment. A University of Michigan study published in this September’s *Health Affairs* projected that under CJR, as the complexity of a hospital’s patient population rose, so would the penalties under the program.¹

Support Exclusion of IME and DSH and Adjustments to EPM Target Prices

¹ Ellimoottil et al. “Medicare’s New Bundled Payment for Joint Replacement May Penalize Hospitals that Treat Medically Complex Patients” *Health Affairs* September 2016 35:91651 – 1657.

AAMC strongly supports CMS's proposal to exclude special Medicare payment provisions, such as the indirect medical education adjustment (IME), disproportionate share hospital (DSH) payments and other add-on payments, from target price and performance period spending calculations.

CMS proposes a series of adjustments to account for AMI episodes that include a CABG readmission and/or have a chained admission, and adjustments for CABG episodes that are triggered by a DRG with major complications. While these adjustments admittedly enhance the complexity of the EPM target price methodology, AAMC commends CMS for attempting to create a target price methodology that accounts for the wide variation in episode payments that are characteristic of these conditions.

Support Inclusion of Reconciliation Payments in EPM and CJR Target Prices

CMS proposes that EPM and CJR target prices would include Medicare repayments or reconciliation payments. Specifically, under CJR, CMS would begin including reconciliation payments in the quality-adjusted target prices for performance years 3, 4, and 5, would include BPCI reconciliation payments in the regional component of the target price. Under EPMs, BPCI reconciliation payments would be included when calculating target prices for all performance years, and EPM reconciliation payments would be incorporated in performance years 3, 4, and 5. AAMC supports this policy, and believes this provision would slow "the race to the bottom", in which efficient providers see their target price continuously decrease to a point where patient safety is at risk and identifiable efficiencies are greatly diminished. In addition, the policy is consistent with rebasing methodologies utilized under the Medicare Shared Savings Program (MSSP). The MSSP Final Rule provided for a rebasing methodology that would account for savings generated by accountable care organizations (ACOs) during the previous performance period (80 *Fed Reg.* at 32788 - 32791).

LIMITS OR ADJUSTMENTS TO PARTICIPANTS' FINANCIAL RESPONSIBILITY

Support Gradual Increase in Stop-Loss Limits

CMS proposes to cap EPM participants' gains and losses in the program in the following manner:

- Cap gains/losses at 5 percent of the target amount in performance year 2;
- Cap gains/losses at 10 percent of the target amount in performance year 3; and
- Cap gains/losses at 20 percent of the target amount in performance years 4 and 5.

AAMC believes it is appropriate to gradually increase EPM participants' financial risk exposure over time, rather than immediately implementing a 20 percent cap. However, as previously noted, AAMC recommends that the upside only period be extended through Q3 of performance year 2. As a result, the 5 percent cap would begin in Q4 of performance year 2. AAMC recommends that the cap of 5 percent be extended by at least one additional quarter, to include Q1 of performance year 3.

Reduce Financial Risk of Hospitals Serving a High Portion of Vulnerable Populations

CMS seeks comment on how hospitals serving a high portion of vulnerable populations should be treated under EPMs. AAMC appreciates CMS's recognition that such providers likely require special treatment, specifically in the form of enhanced financial risk protection. We believe that CMS should apply lower caps on such providers' total losses. While the exact level warrants further study, at a minimum CMS could extend the 5 percent cap to include all of performance year 3, and limit the maximum risk exposure to 10 percent of the target amount in performance years 4 and 5. Granted, executing such a policy would require CMS to establish a definition for "vulnerable populations". AAMC believes that at a minimum it is appropriate that any definition account for Medicaid and uninsured populations. We encourage CMS to promulgate a proposed definition for "vulnerable populations" and seek stakeholder feedback.

AMI, CABG, AND SHFFT QUALITY METRICS AND PERFORMANCE

The AAMC supports the inclusion of quality metrics in the three proposed episode payment models to ensure that all patients undergoing treatment for these conditions receives high quality care. The Association thanks CMS for promoting consistency across the EPMs by proposing a quality scoring methodology that is similar to the approach previously finalized for the CJR program, and which allows multiple opportunities for hospitals to achieve reconciliation payments for superior quality. The AAMC also appreciates that many of the proposed quality measures are currently being reported for the Inpatient Quality Reporting (IQR) program, thereby reducing additional reporting burden for hospital staff. However, quality measures that do not directly relate to the care provided or are not NQF-endorsed or publicly reported should not be included in any payment program. In addition, the Association believes that mortality measures should be adjusted for socio-demographic status (SDS) as these measures are tied to community factors that are typically outside of the direct control of providers. The AAMC has a number of recommended changes to the proposed quality scoring methodology and to the proposed quality measures to improve the EPMs moving forward.

Implement an SDS Adjustment for EPM Mortality Measures

Many outcome measures, such as mortality, are affected by patient's sociodemographic factors. Hospitals that disproportionately care for vulnerable patient populations are disadvantaged when these measures are not appropriately adjusted for SDS. The AAMC urges CMS to ensure that these measures are immediately reviewed under the NQF trial period to determine whether there is a conceptual and empirical relationship between such measure's outcomes and SDS factors.

Expand Eligibility for Improvement Points

Under the proposed AMI and CABG scoring methodology, hospitals are eligible to obtain up to 10 percent of each measure's maximum value through year-to-year improvements in performance. Hospitals are only able to achieve improvement points, however, if they are in the top 10 percent of improvers for all hospitals in the country. For the SHFFT and CJR bundles, hospitals will be rewarded with improvement points by increasing performance by two or more deciles compared to the previous performance year. Voluntary measures are not eligible for improvement points.

The AAMC thanks CMS for incorporating improvement points into the quality performance scoring methodology. Hospitals that implement protocols to improve performance compared to their own baseline should be recognized for these efforts. Unfortunately, the proposed approach to assess improvement under the EPMS limits the opportunity to only those hospitals in the top 10 percent. The intent of improvement points is to incentivize hospitals to implement strategies to improve the quality of patient care. It should not be a system that only rewards certain hospitals that are able to obtain dramatic changes in their scores. For most hospitals in the below acceptable range, it will take considerable effort under the proposed methodology to be eligible for any improvement points despite significant efforts and improvement.

CMS should instead implement a simpler approach that allows hospitals to receive a set number of points depending on the number of deciles they improve compared to prior performance. The Agency could then use the higher of achievement points or improvement points to determine the total score on these certain measures, which is similar to how the hospital Value Based Purchasing (VBP) program assesses improvement in their scoring methodology.

Accurately Report EPM Quality Data on Hospital Compare

The AAMC supports CMS's proposal to publicly report individual hospital's EPM quality performance data on the Hospital Compare website. While the details for how this data will be publicly displayed have not been discussed, we believe that the description of the data should accurately reflect performance. In the rule, CMS stated its intention to place hospitals with insufficient volume on a quality measure at the 50th percentile, which is in the "Good" category used to determine the reconciliation payment discount percentage. In order to ensure that patients are fully informed on this issue, the AAMC believes that hospitals meeting this criterion should not be labeled as "Good" on the website, but instead should be placed in a separate category noting that there was insufficient volume to determine a performance score.

Revise the "Excellent" Threshold

The proposed quality scoring thresholds for each of the three models are divided into four separate categories: "Below Acceptable," "Acceptable," "Good," and "Excellent." These categories directly correspond to the overall performance on the quality metrics for each of the EPMS, and the amount of the payment discount percentage if the hospital is eligible for reconciliation payments. All hospitals are eligible for reconciliation payments, unless their quality performance falls into the "Below Acceptable" bucket.

As described in the rule, CMS heavily skews the point distribution for the three models so that the majority of hospitals fall into the "good" category of performance. As an example, hospitals scoring between 6.9 and 14.8 points would be placed into the "good" category under the AMI EPM, while those scoring greater than 14.8 points would be labeled as "excellent." AAMC performed an analysis of this distribution and found that only 11 percent of all hospitals assessed would be marked as "excellent" performers and 66 percent would be described as "good" performers. The disparity between "good" and "excellent" performance under the CABG model

was even greater. CMS did not provide a detailed policy explanation or rationale in the proposed rule for how this distribution was developed. The AAMC believes that the bar for achieving “excellent” care is set too high, and strongly recommends that the threshold be lowered to allow for more hospitals to be placed into the “excellent” category under the three models. Lowering the “excellent” threshold would correctly recognize additional institutions that are achieving high levels of quality care for their patients.

Support Inclusion of the AMI and CABG Mortality Measures

Under the AMI and CABG models, CMS proposes to adopt the corresponding mortality measures for each condition, which are also reported by hospitals under the IQR and VBP programs. Given the importance of mortality as an outcome measures for patients, the AAMC strongly supports the inclusion of these measures. In addition, these measures are NQF endorsed, publicly reported, and providers have had sufficient time to implement care processes to reduce mortality for those patients most at risk. However, the AAMC strongly recommends that the AMI and CABG mortality measures be immediately reviewed under the NQF’s SDS trial period to determine whether there is a conceptual and empirical relationship between the measure’s outcomes and SDS factors.

Finally, the Association recommends that CMS re-examine the mortality measure methodology to determine which hospital would be “tagged” with a beneficiary that is transferred between two institutions. Currently, under the AMI mortality measure criteria, the transferring hospital is responsible for the patient’s episode, even if the majority of care was provided at a tertiary center. It may be more appropriate for the receiving hospital, which is typically providing higher level and more specialized care, to have these patients included in the measure numerator.

Remove AMI Excess Days in Acute Care (EDAC) Measure

CMS proposed to include the AMI Excess Days in Acute Care (EDAC) measure for the AMI model, which would be weighted at 20 percent of the total score. The EDAC measure assesses all-cause acute care utilization for post-discharge AMI patients and includes readmissions, observation stays, and ED visits. The measure is a ratio of a patient’s actual acute care utilization compared to expected utilization based on the patient’s degree of illness. This measure is not NQF endorsed, has not been adjusted for SDS factors, and is not publicly reported on the Hospital Compare website. Furthermore, the AAMC has concerns as to whether documenting the excess days provides a clear signal of quality. In particular, patients with higher complexity or with difficult personal circumstances may require more days in an acute setting.

The AAMC strongly opposes inclusion of the AMI EDAC measure at this time. At a minimum, any measure that is used to tie hospital payments to performance must first be NQF endorsed, publicly reported on Hospital Compare, and should be evaluated by the MAP. Once these conditions are met, the EDAC AMI measure should also be reviewed to determine whether there is an empirical and conceptual relationship with SDS factors and the measure outcomes. If there is a relationship, the measure should be adjusted to account for these factors.

In addition to the concerns cited, CMS notes in the proposed rule that the Agency does not intend to include a measure of readmissions for the proposed EPMS. The Agency's justification is below:

More specifically, similar to our final decision for the CJR model, we are not proposing to use any readmissions measures that could apply to clinical conditions in these EPMS but that are already in place or have been finalized for the HRRP, specifically the Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following AMI hospitalization (NQF #0505) and the Hospital 30-day all-cause, unplanned, RSRR following CABG surgery (NQF #2515), due to the incentives, already in place by the HRRP, for hospitals to lower excess readmission rates (80 FR CMS-5519-P 294 73479). While we consider these readmissions measure rates to be important metrics for providing information about AMI and CABG hospital performance in the HRRP and HIQR Program for payment and public reporting, respectively, other proposed measures for the AMI and CABG models support the intent of these models to reduce actual payments in an EPM episode while ensuring that quality of care for AMI and CABG model beneficiaries is improved.²

However, the EDAC measure is heavily influenced by a hospital's readmissions, which CMS outlines below when responding to comments on the EDAC measures in the FY 2017 IPPS final rule:

Comment: Several commenters expressed concern that hospitals might be penalized twice for the same readmission, once through the existing readmission measure in Hospital Readmissions Reduction Program and again through the "excess days" measure in Hospital VBP Program (if and when the "excess days" measures are incorporated into the Hospital VBP Program).

Response: The Hospital VBP Program cannot adopt this measure, as section 1886 (o)(2)(A) of the Act prohibits readmission measures under the Hospital VBP Program. With respect to commenters' expressed concern that hospitals might be penalized twice for the same readmission, since readmission measures cannot be adopted into the Hospital VBP Program, hospitals cannot be penalized through the existing readmission measure in Hospital Readmissions Reduction Program and through the "excess days" measure for the same condition in Hospital VBP Program³

For all of these reasons, the AAMC urges CMS to remove the EDAC AMI measure from the AMI EPM and as a result, increase the weight of the mortality measure from 50 percent to 70 percent of the total score. The mortality measure is the only measure that is NQF endorsed and is directly linked to the quality of care provided to patients under this model.

Ensure Patient Experience Survey Aligns with EPM Beneficiaries

² Advancing Care Coordination Through EPMS Proposed Rule; Federal Register P. 50879

³ FY 2017 IPPS Final Rule, Federal Register P. 57146

Similar to the CJR mandatory bundles, CMS proposes to include the HCAHPS survey in the AMI, CABG, and SHFFT models. While AAMC supports the use of patient feedback to assess the overall quality of care, the patient population being assessed under the HCAHPS survey is not aligned with the patient populations in the EPMs as it includes all patients with an inpatient admission, not just those Medicare beneficiaries who experience an AMI, CABG or a THA/TKA episode. Furthermore, the HCAHPS only reflects a patient's inpatient experience, which could potentially be a small part of the patient's experience throughout the episode. The HCAHPS are already a significant part of quality measurement, considering that the survey is included in the Value Based Purchasing Program and in the CJR program. The AAMC strongly recommends that CMS utilize a separate survey option to determine how the EPMs affect the patient experience. CMS could develop a sampling methodology that will allow results to be attributed to individual hospitals for the purpose of determining eligibility for a reconciliation payment.

Adjust AMI Voluntary Measure Performance Period

CMS has proposed to include a voluntary hybrid AMI mortality measure, which would be worth 10 percent of the hospital's total score under the AMI bundle. The voluntary measure would require collection of five EHR abstracted core clinical elements that would be used to modify the measure's risk adjustment. The AAMC supports the inclusion of this voluntary measure in the model, but has concerns with the timeline and reporting requirements for this data. CMS proposes to require hospitals reporting this measure to submit all of the data elements for at least 50 percent of qualifying admissions for two months in 2017 (July and August, 2017) increasing to 90 percent of qualifying admissions over a 12-month period in future year. A requirement that hospitals submit such a significant amount of data on a new reporting system 1 year from the release of the proposed rule is simply not enough time for providers. Hospitals need to redesign their EHRs to collect and validate this data, which would be extremely difficult to accomplish by June of 2017. The AAMC strongly recommends that CMS delay the implementation of this measure until at least 2018.

DO NOT CHANGE PREVIOUSLY FINALIZED CJR SCORING THRESHOLDS

In this rule, CMS proposes to alter the four composite quality score thresholds that were previously finalized under the CJR model. For example, the Agency would increase the minimum for "acceptable" quality (and therefore eligibility for reconciliation payments) from the currently finalized threshold of 4.0 points to 5.0 points. The thresholds for the "good" and "excellent" categories would similarly be increased.

CMS justifies this proposal by stating that the Agency's estimation of savings will not change "because the measure distribution used for such calculations in the CJR final rule was the correct one we describe here."⁴ While the total savings may not change, some hospitals that had budgeted for reconciliation savings due to the thresholds described in the CJR final rule will be forced to cover a funding shortfall due to CMS's misleading descriptions of the program. Hospitals have

⁴ Advancing Care Coordination Through EPMs Proposed Rule; Federal Register P. 50954

extensively modeled and allocated resources to prepare for the impact of these changes, and should not be penalized in order for CMS to maintain previously stated estimation of savings.

At a minimum, the AAMC strongly recommends that CMS ensure that all hospitals that were placed into the “acceptable” category - using the point thresholds described in the CJR final rule - remain in the “acceptable” category in the future.

FINANCIAL ARRANGEMENTS UNDER EPMS

Fraud and Abuse Waivers to Allow Gainsharing Should be Promulgated Expeditiously

CMS proposes to allow gainsharing of Medicare savings and internal costs between hospitals and various providers defined as an “EPM collaborator”. CMS further proposes to allow sharing of downside risk, through the contribution of alignment payments. AAMC supports these options, and notes that similar gainsharing rules have played a key role in BPCI.

Until such time as the fraud and abuse laws can be made consistent with new care delivery systems, it is critical that CMS, the Office of Inspector General (OIG), and other associated agencies coordinate their efforts and rapidly promulgate waivers to those fraud and abuse laws that are identified as impediments to the financial arrangements that support the coordinated care in this proposed rule and in other programs. The highly regulated nature of this program guards against the possibility that patients will be denied care or will be given poor quality care, thus removing the concerns that the fraud and abuse laws were intended to guard against. . Revising contracts to reflect these new financial arrangements can take months; not only do regular contract processes require time, but these new financial arrangements, such as those in BPCI, introduce an entirely new lexicon to providers and hospital legal counsel.

Support Expanded Definition of Program “Collaborator”

Similar to CJR rules, CMS proposes to enable EPM participants to share both savings and responsibility for repaying losses with entities called EPM Collaborators. CMS proposed to broaden the definition for EPM and CJR Collaborators to include ACOs, hospitals and CAHs, and to use this same definition for the EPM models. Hospitals and CAHs would be added to the list as collaborators because there is an expectation that for some beneficiaries, there could be multiple hospitals involved in the episode of care. CMS further proposes adding ACOs as EPM collaborators due to the interest of ACOs in gainsharing during the CJR model rulemaking and the ongoing challenges of addressing overlap between episodes. We concur with CMS’ assertions and believe that additional provider collaborators will further encourage robust care coordination across the continuum. This is especially important where there is overlap with ACOs that threatens to further fragment care if incentives for cooperation are not established. Given the cost structure of CAHs, it is also particularly important that CJR participants are able to legally structure arrangements that account for the increased fixed costs per patient as admissions decline. With razor thin margins, these providers cannot stand to disrupt their financial structure for very long without some form of compensation. We support the addition of hospitals, CAHs and ACOs to the

definition of collaborators under CJR and the consistent application of this definition under the EPM models.

MEDICARE CARE PAYMENT WAIVERS

SNF Waiver Should Apply Beginning in Year 1

CMS proposes to waive various Medicare program rules to enable hospitals participating in EPMs to provide more efficient and coordinated care to EPM patients. AAMC supports policies that afford hospitals operating under alternative payment models the additional flexibility needed to implement such programs.

While the waivers are similar to those provided for BPCI, CMS proposes some key differences. For example, the three-day hospital stay for skilled nursing facility (SNF) payment waiver under an EPM AMI episode would require that beneficiaries must be discharged to a SNF with a three star or higher rating under the Five-Star Quality Rating System for SNFs, whereas BPCI program rules only require that the majority of patients be discharged to a SNF that meets this criteria. Some members of AAMC's BPCI convened group were unable to adopt the three-day SNF waiver due to the lack of adequately ranked SNFs in their region. While prior to 2015, 78 percent of nursing homes scored 4 or 5 stars, recent studies report that 45 percent achieve 4 or 5 stars, with about one-third of SNFs ranking only 1 or 2 stars.⁵ Making a waiver dependent on all SNFs having a 3 star rating or higher would further limit the number of hospitals ability to use the waiver as clinically appropriate. While CMS notes that there is currently at least one 3-star rated SNF in all 294 MSAs that are eligible for selection for the AMI and CABG models, we continue to be concerned that confining the waiver will constrain beneficiary choice. Some patients may have strong family support and prefer to use a two star SNF. Or, if there is only one 3-star SNF in the area, it may simply not have capacity when needed.

In addition, there seems to be no reason why CMS would prevent hospitals from using the three-day SNF waiver until performance year 2. It is important that hospitals be able to implement clinically appropriate care interventions from the onset of the program, as in BPCI. All waivers should apply throughout the entirety of the CCJR program duration.

Additional Protections under the SNF 3-Day Stay Rule Waiver

CMS believes it must include protections for beneficiaries against financial liability for EPM models for non-covered Part A SNF services that might be directly related to use of the SNF 3-day waiver under the applicable EPM. CMS is concerned that the hospital may discharge a beneficiary using the waiver when the beneficiary does not qualify, to a facility that does not qualify or before the waiver applies. CMS is concerned that where the waiver requirements are not met, the SNF could charge the beneficiary for non-covered SNF services. In these cases, CMS

⁵ [Boccuti C, Casillas G, Neuman T. \[Internet\] Reading the Stars: Nursing Home Quality Star Ratings, Nationally and by State. <http://kff.org/report-section/reading-the-stars-nursing-home-quality-star-ratings-nationally-and-by-state-issue-brief/>. Published May 14 2015 Accessed August 19, 2015](http://kff.org/report-section/reading-the-stars-nursing-home-quality-star-ratings-nationally-and-by-state-issue-brief/)

proposes to hold the EPM participant hospital financially responsible for misusing the waiver. We concur that the beneficiary should not be liable if a provider used a waiver in error. However, we are concerned that an independent physician might inappropriately admit to a SNF without the inclusion of the hospital, yet leaving the hospital responsible for the cost of the uncovered SNF services. We believe the SNF has some culpability in receiving a patient under this waiver given it is the facility that will code and bill for such services. CMS should consider ways in which it could ensure the SNFs take steps to ensure the patients they receive qualify under the circumstances outlined by CMS.

In addition, CMS notes under CJR that it would cover furnished SNF services under the waiver if the information available to the provider at the time the waiver was used indicated that the beneficiary was in a CJR episode. This same protection is not explicitly stated in the EPM section of the rule. AAMC recommends that CMS include this same protection in the EPM final rule.

Support Post-Discharge Home Visits

CMS proposes to adopt program requirement waivers for the EPM models similar to the post-discharge home visit waivers implemented for the CJR model. Specifically, CMS would waive the “incident to” rule to permit an EPM beneficiary who does not qualify for home health services (e.g., who is not homebound) to receive post-discharge visits in his or her home or place of residence any time during the episode. AAMC supports the inclusion of a post-discharge home visit waiver for patients who do not otherwise qualify for home health, and the ability to bill for such services outside the global surgical payment. Furthermore, we support allowing licensed clinical staff (employed or not), to furnish the service under the general supervision of a physician (employed or not).

The major difference between the CJR waiver and the proposed EPM waiver is that CMS proposes to impose model-specific limits on the number of visits because current model data show that the average post-acute care LOS may vary or in some cases post-acute care may not be used at all for EPMs. CMS proposes the following model-specific limits on the number of post-discharge home visits:

- AMI Model. A beneficiary in the AMI model could receive up to **13** home visits (i.e., an average of one home visit per week for the entire 90-day AMI episode).
- CABG and SHFFT Models. A beneficiary in the CABG or SHFFT model could receive up to **9** home visits (i.e., an average of one home visit per week for 60 days (two-thirds of the entire 90-day episode)).

While we appreciate the additional allowance of visits for AMI patients, we are not clear what the clinically appropriate number should be for any particular patient. While there may, in some cases, be little post-acute care usage today, part of the goal of the program is to disrupt care patterns to find more effective means to high outcomes. Moreover, differential rules may be confusing for program participants. We support CMS’ proposal for differential post-discharge visit limits at this time, but urge the agency to monitor care patterns and consider refinements in the future with an eye toward consistency.

DATA SHARING

Performance Period Claims Data Should Be Updated Monthly

CMS proposed to provide EPM participants with updated performance period data on a quarterly basis. We appreciate CMS's commitment to provide regular data updates, but believe that monthly data is essential, especially in the beginning stages of the program. As previously noted, the data lag results in the first quarter of performance period data containing only incomplete episodes. While AAMC understands that this reality is a natural result of the claims billing and run out process, EPM participants should be given as much data as possible as soon as possible.

Reconciliation Results Should be provided on a Quarterly Basis

CMS proposes to conduct an annual retrospective reconciliation for EPMs. This strategy would reduce the variation in financial results that stems from the current quarterly reconciliation process in BPCI. Under BPCI, performance periods are reconciled on a quarterly basis, and undergo an initial reconciliation followed by three true ups. While the variation in net payment reconciliation amounts (NPRA) across true ups does pose some uncertainty, providers benefit from the ability to track their financial performance on a quarterly basis. These quarterly results enable providers to assess their performance and understand if care interventions are working, or need to be altered. AAMC conducts quarterly calls with members of our BPCI convened group to understand why they are gaining or losing in BPCI, and regularly ends the calls with key observations and actionable takeaways. Preventing this quarterly review would delay the implementation of important care interventions that stand to improve patient care and the financial performance of the program.

Aggregate Regional Data Should Include Utilization Benchmarks

AAMC supports the CMS proposal to provide EPM participants with aggregate regional data that includes information about average episode payments by provider setting. However, we believe this data can be made more actionable by including key utilization metrics such as:

- Readmission rate;
- Percent of episodes with at least one readmission;
- Percent of episodes that include skilled nursing facility (SNF) care;
- Percent of episodes that include home health care;
- Percent of episodes that include an inpatient rehabilitation (IP rehab) stay;
- Index hospitalization average length of stay (ALOS);
- SNF ALOS for episodes that include SNF; and
- IP rehab ALOS for episodes that include IP rehab.

These metrics would serve as benchmarks for EPM participants, and help identify opportunities for improvement and inform care intervention strategies.

Support Proposal to Allow EPM Participants to Share Beneficiary-Identifiable Data

AAMC supports CMS's proposal to allow EPM participants to share beneficiary identifiable data with entities with which the hospital has a business associate agreement (BAA). Experience shows that data sharing is an excellent strategy for engaging providers. Data can be a catalyst for change; many BPCI participant hospitals use data to educate their physicians about the value of considering changes in their discharge disposition, or to recognize that patient case-mix alone cannot explain a higher readmission rate. Data sharing also inspires collaboration; hospitals and post-acute care providers are more likely to come together to conduct root cause analyses of adverse patient care events so that both entities learn from the bundled payment program data.

Provide De-identified Substance Use Data

Beneficiary information that is subject to regulations regarding the confidentiality of alcohol and drug abuse patient records would not be included in any beneficiary identifiable claims data shared with a hospital under this proposal. CMS currently does not provide data related to substance use diagnoses (primary or secondary codes) and services in the monthly CCLF files. While we understand the sensitivity of such services and CMS's exclusion of them in the files, we think there are options that would provide bundlers with more information, but not risk beneficiary privacy. We therefore urge CMS to provide the de-identified cost and claim data for these services. If this is not possible, at minimum, CMS should provide the aggregate payment amount of these services in the monthly CCLF files.

SUPPORT CARDIAC REHABILITATION (CR) INCENTIVE PAYMENT PROGRAM; CONSIDER WAIVING BENEFICIARY COPAYS

CMS also proposed to establish a Cardiac Rehabilitation (CR) Incentive Payment Model, which would provide bonus payments for CR/ICR services. The first 11 services will trigger individual incentive payments of \$25 per service. Every service thereafter will result in a hospital receiving an incentive payment of \$175. The program is founded on the belief that CR/ICR services can reduce cardiac mortality but are currently significantly underutilized. The design of the program is meant to enable the comparison of how incentivizing the provision of CR and ICR services differs under traditional fee for service versus a bundled payment program. As a result, CMS will be selecting 45 MSAs from the group of 98 EPM MSAs, and 45 MSAs from the MSAs not selected for participation in an EPM. Hospitals in these 90 MSAs will participate in the CR Incentive program. AAMC supports the goal and design of this program. However, we are concerned that the presence of beneficiary copays may inhibit the success of this model. AAMC encourages CMS to explore the opportunity to waive beneficiary copays after a patient receives a certain number of CR/ICR services in order to encourage patient engagement in this program.

CONCLUSION

Thank you for the opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic medical center community. If you have questions regarding EPM payment issues please feel free to contact

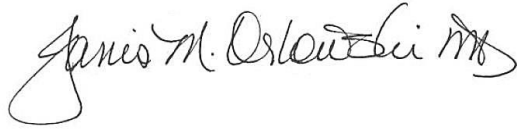
Acting Administrator Slavitt

October 3, 2016

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Jessica Walradt at 202-862-6067 or jwalradt@aamc.org. For questions regarding the EPM quality provisions please contact Scott Wetzel at 202-828-0495 or swetzel@aamc.org.

Sincerely,

A handwritten signature in black ink that reads "Janis M. Orlowski M.D.". The signature is fluid and cursive, with a large initial "J" and "M".

Janis M. Orlowski, M.D., M.A.C.P.
Chief, Health Care Affairs, AAMC

cc: Ivy Baer, J.D., AAMC
Jessica Walradt, M.S., AAMC
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