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Via Electronic Submission (CMMI_NewDirection@cms.hhs.gov)

November 20, 2017

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-8013

Re: Centers for Medicare and Medicaid Services: Innovation Center New Direction, Request for Information

Dear Administrator Verma:

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS's or the Agency's) Request for Information entitled, *Innovation Center New Direction.* The AAMC is a not-for-profit association representing all 149 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 serves the leaders of America's medical schools and teaching hospitals and their nearly 167,000 full-time faculty members, 88,000 medical students, and 124,000 resident physicians.

As a facilitator convener under the Bundled Payments for Care Improvement (BPCI) initiative, the AAMC has a deep interest in the promise of bundled payments to create the right incentives for the provision of high quality, efficient, and lower cost care. AAMC also provides support for providers implementing the Comprehensive Care for Joint Replacement (CJR) program and Oncology Care Model (OCM). Altogether, AAMC actively supports over 50 hospitals and their providers that are engaged in Medicare bundled payment programs. The lessons garnered from this experience heavily inform the content of the AAMC's comments.

AAMC commends CMS for its willingness to incorporate stakeholder feedback into the future direction of the Innovation Center (CMMI), as well as the development of new payment models. The Association shares CMMI's commitment to the transition from fee-for-service to value-based care and believes that CMMI's leadership will continue to accelerate this transition. As CMMI

explores future model development, the AAMC encourages CMMI to consider the following overarching recommendations:

- Continue Medicare's role as a leader in value-based care;
- Maintain the Innovation Center's agility/dynamism with regard to its ability to rapidly respond to stakeholder feedback with appropriate programmatic changes;
- Create more opportunities for providers to participate in Advanced Alternative Payment Models (APMs) through increased flexibility and the introduction of new programs; and
- Include APM participation options designed specifically for academic medical centers (AMCs).

AAMC also urges CMS to adopt several recommendations regarding waivers, beneficiary protections, physician specialty models, health equity, Medicare Advantage, and Medicaid models, which are detailed later in this letter.

MEDICARE IS UNIQUELY POSITIONED TO TEST VALUE-BASED CARE MODELS

In the RFI, CMS discusses the promise of market-driven solutions. While the private sector has an important role to play in delivery and payment reform, public payers, specifically Medicare, are uniquely positioned to test value-based care models. As the single largest payer in the United States, CMS strongly influences the private insurance market. In many ways, CMS is also able to implement programs that are best able to give providers the information necessary to achieve meaningful and comprehensive care transformation. Providers participating in Medicare APMs benefit from two major design elements:

1) Comprehensive historical and current beneficiary claims data; and
2) Uniform programmatic design.

As part of their participation in Medicare APMs, providers receive beneficiary-level claims data for all services provided to a beneficiary during the baseline and performance periods. Providers are able to see what has happened to their patients, regardless of whether or not the care was provided within their facility. As a result, providers can both drill down into a single case and understand why a patient readmitted to another hospital and observe broad utilization and cost trends across all care settings. The breadth and depth of this data enables providers to identify targeted care interventions, and also serves as one of the primary reasons providers elect to participate in Medicare APMs. While private payers also execute APMs, the data shared with providers often pales in comparison to the Medicare claims data. Some payers elect to only provide high-level summary statistics such as overall 30-day readmission rates. Of the private payers who do provide claims-level data, many typically exclude claims for care received outside of a physician group practice or health system.

In addition, if a health system wants to engage with multiple private payers, each of which has its own major joint replacement (MJR) bundled payment model, the provider will have to comply with a myriad of rules and specialize implementation strategies by payer. In contrast, providers participating in Medicare APMs benefit from the assurance that all of their eligible Medicare fee-for-service (FFS) patients will fall under a single program.

Once again, AAMC reiterates its belief that Medicare is a prime testing ground for value-based care models, and applauds CMS for the great work conducted by CMMI to date.

MAINTAIN THE INNOVATION CENTER'S AGILITY AND DYNAMISM

In order to continue to test value-based care models, the Association encourages CMMI to maintain the Innovation Center's agility and responsiveness to stakeholder feedback. AAMC has worked as a partner to CMS since 2014, and seen the benefit of CMMI's ability to listen to stakeholder feedback and make rapid programmatic changes. This agility is especially characteristic of voluntary models such as BPCI and OCM, which do not require notice and comment rulemaking in order to alter program rules.

Ideally, an APM is designed such that patient care is improved and providers are held accountable for factors within their control, typically through the use of risk adjustment or clinical exclusions. In AAMC's experience, when a stakeholder identifies a program rule that does not improve patient care or unfairly penalizes providers, CMMI has been receptive to provider concerns and alternative solutions. A sample of changes CMMI has executed in response to AAMC's member concerns is below:

- **BPCI MJR fracture-stratified target pricing:** BPCI MJR participants identified that fracture patients typically have higher costs and utilization across a 90 day episode when compared to elective MJR patients. As a result, CMMI stratified MJR BPCI and CJR target prices by fracture status in order to accurately capture the higher acuity of fracture patients.
- **Cap quarterly trend factors in BPCI:** BPCI utilizes a quarterly retrospective reconciliation methodology, meaning that new target prices are established every quarter. Providers were concerned about the potential variation in targets across time, especially for low volume DRGs that could regularly experience quarterly changes of +/- 5%. CMMI responded by capping changes in the trend factor between quarters by 3.5%.
- **Revise OCM reporting timelines:** OCM participants are required to submit a great deal of clinical, staging, and quality data to CMS. Much of this data is extracted from pre-existing tumor registries. CMMI originally required quarterly reporting with a minor lag. This timeline created a significant challenge for OCM participants, whose tumor registries typically operate on a six-month delay. In response to this information, CMMI shifted to biannual reporting and established a longer time lag.

CMMI's willingness to collaborate with stakeholders has enhanced the BPCI and OCM models, and will remain critical to the success of future models.

Incorporate Successful Elements of Existing Risk-Based Models into Future Demonstrations

In the AAMC's experience, provisions that maximize provider flexibility and encourage adoption of APMs are critical to the success of a demonstration, including:

- Flexibility to select clinical episodes for which to assume risk;
- Timely access to baseline data prior to the model start date;

- The option to elect upside-only risk (no downside risk for providers) during the first performance year of any new risk-based APM;
- Caps on total losses that start small and gradually increase over time;
- Waivers of various Medicare payment and fraud and abuse rules;
- Reduction in financial responsibility for payments above a threshold on an individual-episode basis; and
- Meaningful quality metrics.

In BPCI, CMS grants providers considerable flexibility in testing new clinical episodes. As hospitals have become more experienced in the implementation of bundled payment models, providers have learned which clinical episodes their institutions are best positioned to test, and conversely, which episodes are not conducive to a bundling design. CMS' current policy of permitting episode initiators to drop a specific clinical episode as long as the hospital provides sufficient notice allows providers to experiment in quality and care delivery model changes which improve the continuum of care. AAMC recommends that CMS incorporate similar provisions allowing providers flexibility in testing episodes in the next iteration of BPCI, or BPCI Advanced.

Under BPCI, CMS provided baseline data to hospitals one year prior to the model start date. Consequently, the AMCs of the AAMC's BPCI collaborative had adequate time to analyze the data, identify high-risk patients, and mitigate risks to patients and program goals. The information gleaned from the baseline data was crucial to many AMC's early successes in BPCI. Sites considering participation in BPCI Advanced (or other future models) deserve the same timeline in order to increase the chance of success.

As the AAMC has commented in prior letters, providers must be sufficiently insulated from downside risk, whether at the aggregate or episode level, to encourage adoption of APMs. As providers experiment in quality and care delivery model changes, they must be afforded the option of at least one year of no downside risk in order to detect utilization trends and identify opportunities for intervention. Because there is a substantial time lag between when a service is rendered and when a provider receives the corresponding claim due to claims runoff, providers are unlikely to gain actionable insights to improve financial performance within less than one year of participation. When designing current voluntary bundled payment models such as BPCI and OCM, CMS recognized the importance of gradually phased-in risk by eliminating downside risk in the first performance period of BPCI, or, in the case of OCM, by instituting downside risk only after multiple performance periods. By allowing providers a gradual on-ramp to risk, CMS has encouraged providers which otherwise would not have participated in voluntary programs to join alternative payment models.

In addition to allowing providers the option to elect upside only risk in the first performance period, CMS should also incorporate caps on total losses that start small and gradually increase over time into future models. In the CJR program, CMS gradually increases downside risk through rising stop-loss limits as the program progresses, eventually capping losses at 20% of the performance period target amount. This has enabled hospitals to experiment in care redesign efforts while mitigating financial risk, advancing CMMI's goal to transition towards value-based care arrangements.

Equally important as the caps on aggregate risk, the cap on risk at the episode level has encouraged providers to assume increasing financial responsibility for the entire episode of care. In the BPCI and CJR models, CMS trims episode costs included in reconciliation calculations above a threshold through Winsorization, effectively reducing financial risk for outlier cases. By decreasing losses that may not be due to provider performance, but rather high-risk patients in need of unavoidable catastrophic care, CMS has incentivized providers to join and continue participating in the BPCI model. As the Innovation Center evaluates future models, the Association encourages CMS to incorporate similar provisions to reduce provider financial risk at both the aggregate and episodic level. The fact that CMS has stated its preference for voluntary models underscores the importance of the AAMC's recommendation, since hospitals, physicians, and other providers must have adequate incentives to join a risk-based model.

Lastly, the inclusion of meaningful quality measures in current models such as CJR has rewarded high-quality hospitals for excellent care. By predicating discounts, and thus financial outcomes on performance on NQF endorsed and nationally validated quality measures, such as the total hip arthroplasty/total knee arthroplasty complications measure and HCAHPS scores, CMS has rewarded high-performing hospitals for excellent quality and patient care. While the Association has concerns with the reporting of the patient reported outcomes data in the CJR model, the AAMC is encouraged by CMS' effort to include meaningful quality measures in payment reform.

INCLUDE PARTICIPATION OPTIONS FOR ACADEMIC MEDICAL CENTERS WHEN DESIGNING NEW MODELS OF CARE

As CMMI explores future model development, the Association urges CMS to continue the longstanding tradition of recognizing the unique mission of academic medical centers. AMCs serve a crucial mission by treating the sickest and most vulnerable patients, redesigning care, addressing the social determinants of health, engaging in research, and teaching the next generation of physicians and other health care providers. Inclusion of the indirect medical education adjustment (IME), disproportionate share hospital (DSH) payments, and other add-on payments in future bundled payment model baseline data and target prices may inadvertently create perverse incentives for post-acute care providers and physician group practices to refer patients away from teaching hospitals, even if those are the best institutions to care for patients. Thus, AAMC strongly supports CMS's current policy excluding special Medicare payment provisions, such as IME, DSH payments, and other add-on payments, from CJR target price and performance period spending calculations. In order to facilitate academic medical center participation in future models, the AAMC urges CMMI to continue to exclude special Medicare payment provisions from future bundled payment model target price and performance period spending calculations.

Additionally, as HHS continues to evaluate future physician-led models through the Physician Technical Advisory Committee, or PTAC, the AAMC urges CMS to develop more models under which hospitals have the opportunity to act as the at-risk participants. Throughout the course of BPCI, AAMC has observed that hospitals are best poised to bring providers together to fundamentally change the provision of care to increase the value and patient experience of care. Furthermore, hospitals are more likely to have the necessary supportive resources such as administrative staff and analytic expertise, as well as the revenue base to shoulder the

programmatic risk. Many APMs include significant reporting requirements that are best implemented by administrative staff, not physicians who already spend an inordinate amount of time recording clinical data during charting. That being said, the most successful hospital participants know that for a model to succeed they must engage clinicians. Many of AAMC's APM participant members dedicate significant time to garnering physician buy-in, as they know change is not possible without clinicians. Many of these hospitals also financially compensate physicians by gainsharing Medicare savings and/or altering internal compensation models.

In conclusion, creating opportunities for hospital participation in APMs is not intended to exclude other providers. On the contrary, the inclusion of hospitals is meant to generate options for more clinicians to be QPs and to ensure that more risk-bearing providers have the necessary financial and staff resources to ensure program success.

CREATE MORE OPPORTUNITIES FOR PROVIDERS TO PARTICIPATE IN ADVANCED APMS

Under the Quality Payment Program (QPP), eligible clinicians (ECs) have the option to either participate in the Merit-Based Incentive Payment System (MIPS) program and receive adjustments to payment, or participate in an Advanced APM, which may potentially qualify the EC to receive a 5% payment bonus. In order to receive the 5% bonus payment, clinicians must participate in Advanced APMs and must meet certain thresholds of Medicare patients or payments provided through those APMs. If the clinicians are determined to be qualifying participants (QPs) they will not be subject to MIPS.

While the QPP may not fall solely under the authority of CMMI, the Innovation Center discusses its intention to create more opportunities for ECs to participate in Advanced APMs. Since CMMI will have an important role in developing these models, the AAMC recommends that CMMI coordinate with CMS to:

- Continue to build a portfolio of additional Advanced APMs that would allow participation for a broad range of physicians and other practitioners;
- Design the program to maximize participation in Advanced APMs for physicians and other practitioners by designating more APMs as Advanced APMs;
- Implement flexible requirements regarding the classification of Advanced APM participants;
- Recognize that risk in excess of a nominal amount can be demonstrated in a variety of ways;
- Allow a tenable on-ramp for increased risk;
- Give credit for APM participation to physicians working with their partner teaching and other hospitals in APM risk-based models; and
- Enable providers to know whether or not they are QPs with sufficient time to allow those physicians to determine whether MIPS participation is required.

Enable More Eligible Clinicians to Achieve the Qualifying or Partial Qualifying APM Threshold

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established threshold requirements stipulating the percent of Medicare payments and patients an APM must meet for its clinicians to become QPs or partial QPs. In the first year, the threshold is 25% for Medicare payments and 20% for patients. The Medicare threshold for payments will increase to 75% in 2023.

The AAMC recommends 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 treat 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, removing the possibility of attributing such patients to the numerator. Already, CMS has excluded these 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 future threshold of 75% will be very challenging and few eligible clinicians may be able to meet it. The Association recognizes that this threshold is set in statute and encourages CMS to work with stakeholders to monitor this potential problem. In conjunction with stakeholders, CMS can provide actionable data to Congress to consider future legislative relief.

Starting in 2021, a clinician may achieve 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. For a clinician to attain QP status through the All-Payer Combination Option, either the payer or the eligible clinician must submit detailed information to CMS for a determination made at the individual clinician level. The AAMC has significant concerns with the approach to the All-Payer combination, since this option presents major operational challenges for eligible clinicians as compared to the Medicare option. Requiring eligible clinicians to report the information to CMS would not only be extremely burdensome and time-consuming, but would also require unnecessary duplicative effort on the part of each clinician. Additionally, eligible clinicians may be limited in their ability to share some of the information with CMS, as there may be constraints in their contractual arrangements with the payer. Instead of requiring that eligible clinicians submit this information if the payer does not, CMS should require the payers to submit this information to CMS, since payers have the administrative capacity to do so.

Eliminate the 50 Clinician Cap on Medical Home Models Qualifying as an Advanced APM

According to MACRA, an Advanced APM must either: 1) be a Medical Home model expanded under section 1115A(c), 2) or bear financial risk in excess of a nominal amount. CMS proposed that 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 of organizational size for Medical Home models. This 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 coordinated, culturally appropriate care. Excluding these medical homes simply based on size will discourage large groups from seeking this designation. Therefore, CMS should eliminate the 50-clinician cap on medical homes eligible to qualify as Advanced APMs.

Implement Physician-focused Payment Models and Develop a Fast-Track Process for Their Approval

The MACRA statute established a Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review proposed physician-focused payment models (PFPMs), providing an opportunity for stakeholders to propose additional qualifying Advanced APMs. CMS established PFPM criteria organized into three categories including: 1) providing payment incentives for higher-value care, 2) addressing care delivery improvements that promote better care, and 3) addressing information enhancements that improve the availability of information to guide decision-making. While it is critical that the MACRA regulations establish a clear pathway for models to be proposed to the PTAC, the pathway should be less stringent than proposed and encourage more submissions of PFPMs.

The process to develop, approve, and implement PFPMs is lengthy. CMS should recognize the upfront investment of time and energy needed to first develop these models, the subsequent time required for committee review, followed by the additional time necessary for practices to implement operational and infrastructure changes. Because the 5% bonus is only available for 5 years, and the process required to implement a PFPM is lengthy, some physician specialties will have a very limited window during which they will be eligible to receive the 5% bonus. While the increased payment update will be available for eligible clinicians in qualifying APMs starting in 2026, it is unfair to establish a system that may result in large numbers of physician specialties being unable to take advantage of the early 5% bonus.

CMS notes that it normally takes the Agency 18 months to develop an APM. Additional time is needed for the entities to complete applications, for CMS to review them and then prepare participation agreements. This process is not only time-consuming, but also disadvantages those who need adequate time to operationalize and implement PFPMs. Instead, CMS should establish a "fast track" approval mechanism which will create a more efficient process. Otherwise, the opportunity for the physician community to participate in PFPMs will be merely theoretical, undermining the intent of the statutory provision.

CONTINUE TO EXPLORE PHYSICIAN SPECIALTY MODELS; CAUTION AGAINST PREPAID CANCER MODEL

AAMC champions CMS' goal to create participation opportunities for all types of clinicians in Advanced APMs, and supports efforts to increase the availability of specialty physician models. Among physician specialty model options, CMS specifically noted a cancer care model that would test "full prepayment for Medicare and Medicaid beneficiaries". AAMC interpreted this section as describing a prospective bundled payment program for cancer episodes. While the Association supports the exploration of cancer bundle programs, such as the Oncology Care Model (OCM), we strongly advise against the creation of program in which prospectively set amounts are paid to providers for cancer care at the outset of a program or episode.

In order for a "prepaid" or prospective episode-based payment model to potentially be successful, two primary conditions must be met:

1. **Participating providers must have the ability to act as a (or pay to engage the services of) a third party administrator.** Under a "prepaid" model, providers receive a prospectively set payment for each episode. If actual payments for services rendered to a patient during an episode fall below the prepaid amount, the provider will realize savings. Conversely, if actual payments exceed the prepaid amount, the provider will sustain a loss. Unlike a retrospective model in which providers continue to be paid fee-for-service during a program and either receive or owe money after a performance period, in a prospective payment model, there is no exchange of funds between Medicare and a provider upon reconciliation. However, if an episode encompasses all services delivered to a patient across a period of time, the provider that acts as the financial awardee would be responsible for reimbursing all other providers involved in the beneficiaries' care.
2. **Program designers must be able to set an appropriately risk-adjusted prospective payment for the condition in question.** The intent of episode-specific payment models is to design a target price methodology that holds providers accountable for the factors they can control while adequately risk adjusting for the factors beyond their control. In order to apply adequate prospective risk adjustment, two criteria must be met:
    - Program designers must have enough upfront information about a given patient; and
    - The condition in question must have low to moderate variability in utilization across time.

Most providers have a difficult time satisfying the first element regardless of the clinical condition. Some providers circumvent this challenge by paying an outside entity to serve as the third party administrator. Granted, this option is costly. Alternatively, some program designers have sought to eliminate the challenge by limiting the number and types of services included in the episode definition. For example, BPCI Model 4 episodes only encompassed an index inpatient stay and 30-day related readmissions while excluding all other post-acute care. Regardless, providers still struggled to administer the model and participation steadily dropped. As of October 2017, only two hospitals remained in BPCI Model 4.

Meanwhile, the second element is especially difficult to satisfy when dealing with cancer episodes. Cancer care is highly variable, and many of the factors that drive this variation such as clinical/pathological stage and/or the presence of certain mutations are not found in claims data. This fact makes establishing an adequately risk-adjusted prepaid amount for a cancer episode nearly impossible. For this reason, CMMI requires OCM participants to submit clinical and staging data on a biannual basis such that it may be used to eventually develop more robust risk-adjusted target prices. Even with sufficient risk adjustment, cancer treatment costs are difficult to predict over a long period of time. OCM participants' experience attempting to calculate the total cost of care for OCM patients illustrates this fact. Estimates that rely on historical claims data are off by huge magnitudes. Even estimates calculated with internal clinical data and based on actual individualized treatment plans are usually incorrect, since treatment plans can and do often change

based on a patient's response to chemotherapy. For example, an adverse response may force a care team to recommend a completely new chemotherapy regimen.

In conclusion, a prepaid model for cancer treatment would be administratively difficult to administer, and technically difficult to price. While AAMC believes that CMS must continue to grow and pursue cancer-focused value-based care models, we discourage CMS from adopting a model that would test full prepayment for cancer treatment.

EXPAND PAYMENT WAIVERS TO FUTURE MODELS

CMS established waivers of Medicare payment rules for many APMs such as the NextGen ACO, CJR, and BPCI models to facilitate payment and delivery reform. Existing payment waivers permit providers participating in these models to discharge beneficiaries to skilled nursing facilities (SNFs) without a three day hospital stay, and expand access to telehealth and home health. AAMC urges CMMI to extend existing payment waivers to future models, as discussed in more detail below.

Extend CJR SNF Waiver Protections to Other APMs

Medicare rules stipulate that a beneficiary must, at a minimum, have a three-day hospital stay in order to qualify for coverage for a SNF stay. This requirement does not always align with patient needs or the most appropriate care for patients, and may instead hinder care coordination. The three-day hospital stay requirement for SNF payment poses an impediment to providers attempting to reduce costs and improve quality, as there are patients for whom the most appropriate care is to be admitted to a SNF after a short hospitalization, or after an observation stay. However, under current rules this would mean that the Medicare beneficiary would be entirely responsible for the substantial costs associated with a SNF stay, an untenable situation for many beneficiaries. In order to improve care coordination and advance program goals, CMS allows hospitals in BPCI and CJR to waive the SNF three-day rule, provided that certain model specific requirements are met.

Under BPCI, the 3 day stay requirement is waived as long as: 1) a beneficiary remains eligible for BPCI throughout the entirety of the 90 day post-discharge period; and 2) the majority of SNFs receiving a participant's BPCI patients has a three star rating for at least seven months of the last calendar year. Currently, the BPCI SNF waiver does not provide adequate safeguards against beneficiary financial liability in instances in which a BPCI beneficiary's Medicare coverage status, and thus eligibility, changes during the episode. If a beneficiary's Medicare coverage changes during a BPCI episode, the episode will ultimately be dropped, meaning the patient did not actually qualify for the waiver. As a result, a beneficiary may be financially liable for the cost of uncovered SNF care.

In the absence of explicit CMMI policy to protect patients, some BPCI hospitals are hesitant to utilize the SNF waiver based on the potential adverse financial consequences for patients. While a beneficiary may be eligible for BPCI upon discharge, their eligibility status could change post-discharge. Hospitals cannot predict this change. Therefore, in order to prevent patients from potentially receiving a bill for uncovered SNF care, BPCI hospitals are opting not to utilize the Waiver of the 3-Day Hospital Stay Requirement for SNF Payment.

In contrast, CJR hospitals utilizing the three-day waiver benefit from the assurance that CMS will hold beneficiaries harmless for uncovered SNF care resulting from changes in beneficiary eligibility status during the course of an episode. In the Episode Payment Model (EPM) Final Rule, which contained changes to CJR, CMMI specifies that CMS "…will cover services furnished under the SNF waiver in cases where the beneficiary met the criteria at §510.205 on the date of discharge from the anchor hospitalization, based on information available as of that date".[1] That is, CMS will cover SNF care as long as the information available at the time of discharge indicated that the beneficiary was eligible for CJR. This policy has encouraged adoption of the CJR SNF waiver, and, ultimately facilitated hospitals' care redesign efforts.

In light of hospitals' experiences utilizing the SNF waivers, AAMC urges CMMI to extend the CJR three-day stay waiver for SNF payment to all APMs.

Expand CJR and NextGen Telehealth Waivers to Additional APMs

The general Medicare rules related to payment for telehealth services are that the services must be provided to a patient in a rural area and at an originating site defined by CMS. This significantly restricts the number of patients who can access telehealth services, and limits physicians in their provision of these services. Under these guidelines, patients must reside in a rural area and access telehealth services from a defined list of originating sites. The originating sites for telehealth services include hospitals, clinics, certain centers, and skilled nursing facilities. The home is not included as an originating site. Many patients would benefit from telehealth services, but are unable to access a qualified originating site, disqualifying them from receiving telehealth services. Additionally, patients in urban and other non-rural areas who do not have convenient access to a provider could benefit from telehealth as well, but are not generally permitted to access telehealth services. As currently defined, patients must present from an originating site located in a county outside of a Metropolitan Statistical Area (MSA) or in a rural Health Professional Shortage Area (HPSA).

The BPCI, CJR, and the NextGen ACO models all offer waivers of these requirements, allowing broader use of telehealth. While the BPCI model only waives geographic site requirements, the CJR model also waives the originating site requirements and the facility fee if the service originated in the beneficiary's home. The NextGen ACO model similarly waives the rural geographic component of the originating site requirements and permits the originating site to include a beneficiary's home. Consequently, the CJR and NextGen ACO telehealth waivers increase patient access to telehealth, especially for homebound beneficiaries, since they allow beneficiaries to receive telehealth services in their home, rather than at a healthcare facility. These waivers dramatically expand beneficiary access to telehealth and create new vehicles for academic medical centers to provide care to patients. CMS should expand the telehealth waivers offered in the CJR and NextGen ACO models to additional alternative payment models. As Medicare payments are increasingly predicated on quality, there is little risk that providers will use these services for purposes other than to deliver the best quality, most cost-efficient care.

[1] Advancing Care Coordination through EPMs Final Rule, 82 Fed. Reg. 1, (January 3, 2017).

Extend CJR Post-Discharge Home Health Visit Waiver to Additional APMs

The post-discharge home health visit waiver waives the incident to rule to provide coverage under Part B for a specified number of post-discharge home visits during a BPCI or CJR episode to non-homebound beneficiaries under the general supervision of a physician. In contrast to the traditional Medicare home health benefit, which only covers home health for homebound beneficiaries, the BPCI and CJR post discharge home visit waivers allow non-homebound beneficiaries to receive home health care. However, the CJR post discharge home visit waiver affords providers more flexibility, since CJR program rules allow providers to bill up to nine visits per episode under Part B, whereas BPCI only allows providers to bill up to three visits in the same timeframe.

Both patients and providers benefit from post discharge home health visit waivers, as home health agencies are able to identify mobility barriers and develop exercise regimens for beneficiaries recovering from an inpatient admission. While AAMC appreciates CMMI's adoption of post discharge home health visit waivers in BPCI and CJR, the Association recommends that CMMI expand the waiver utilized in CJR to future models.

SAFEGUARD BENEFICIARY PROTECTIONS

In the RFI, CMS indicates that the Agency desires to develop models to facilitate increased competition, consumerism, and quality and price transparency. Specifically, CMS states that the Agency is considering testing models which would permit beneficiaries to contract directly with healthcare providers, or to allow beneficiaries to retain a portion of shared savings if they elect a lower cost option. The AAMC supports initiatives to improve quality and price transparency. The current fee for service and Medicare Advantage models are well-proven forms of care delivery, though are susceptible to improvement. Existing alternative payment models provide many options to beneficiaries and ways to improve the quality of care and lower health care costs. The Association is concerned that negotiating directly with providers would not be advantageous to beneficiaries as the two parties would not have equal negotiating power, potentially creating more confusion for beneficiaries and significantly changing the nature of the physician-patient relationship. Any model ideas which would so fundamentally alter this relationship must be thoroughly vetted by patient advocacy groups and other stakeholders.

The Medicare program is incredibly complex, and many seniors already struggle to navigate basic Medicare coverage. While some beneficiaries may be savvy enough to contract directly with providers, allowing all beneficiaries in a model to engage in this effort may make Medicare benefits even more confusing.

The CMS' proposal to allow beneficiaries to retain a portion of shared savings may place the most vulnerable beneficiaries at risk. Currently, CMS only allows providers in Accountable Care Organizations (ACOs) and bundled payment models to share savings and/or losses resulting from the provision of care, recognizing that gainsharing with patients may create more harm than good. If the policy is not properly communicated to beneficiaries, and sufficient beneficiary protections are not put in place, beneficiaries may be incentivized to choose lower cost options in order to receive savings, but may suffer if CMS does not ensure that quality of care is not reduced. As such, the AAMC recommends that CMS engage with patient advocacy groups and other stakeholders to

develop models to empower beneficiaries. At this time it is premature to make coverage and/or care decisions more complex for beneficiaries.

INCORPORATE A HEALTH EQUITY FOCUS INTO MODEL DEVELOPMENT

The AAMC applauds CMMI's efforts to test the effectiveness and impact of social needs screening via their Accountable Health Communities model, and encourages CMMI to continue the development of national data collection standards for patient- and community-level social factors that impact local healthcare quality and health outcomes. Efforts to adjust for and compare social risk factors in future CMMI models will be hindered in the absence of nationally available, standardized data.

Similarly, we encourage CMMI to develop and test models that will incentivize health systems' focus on disparity reduction by requiring and rewarding the development of interventions designed to reduce local health care delivery and quality inequities. For example, CMMI could incentivize health systems to develop the capabilities to stratify quality and clinical data by social risk factors.

EXPAND MEDICARE ADVANTAGE VALUE-BASED INSURANCE DESIGN MODEL TO ALL 50 STATES

In the RFI, CMMI announced that the Agency may modify the Medicare Advantage Value-based Insurance Design (MA VBID) model or expand the demonstration to additional states. Currently, the MA VBID model is being tested in seven states, and will expand to include three additional states in 2018, allowing participant MA plans the flexibility to offer differing benefit designs for enrollees with certain chronic conditions. The AAMC believes that CMS should expand the model to all 50 states in 2019 to allow additional MA plans to voluntarily test whether VBID concepts truly improve patient outcomes and reduce healthcare costs. A national expansion of the MA-VBID model would allow CMMI to more robustly evaluate the impact of varied benefit design on utilization, spending, and beneficiary outcomes.

CREATE MORE PARTICIPATION OPPORTUNITIES IN STATE AND LOCAL MODELS

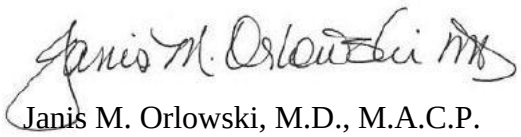
CMMI discussed its goal to partner with states to improve health outcomes, and its intent to consider models specific to the Medicaid population. The AAMC applauds CMMI's efforts to test innovative Medicaid models, including State Innovation models and the Medicaid Incentives for the Prevention of Chronic Disease. As CMMI develops more state Medicaid and locally-based models, AAMC encourages the Agency to partner with academic medical centers (AMCs). Many large AMCs serve as the source of sub specialty care for Medicaid beneficiaries, and treat the most vulnerable and sick patients. Therefore, many AMCs could be well equipped to experiment in Medicaid payment and delivery reforms.

While allowing flexibility in the design of such programs across localities is an appropriate recognition of the divergent needs and capabilities of providers in different regions, AAMC strongly encourages CMMI to facilitate shared learning opportunities across model participants.

CONCLUSION

Thank you for the opportunity to present our views. We would welcome the opportunity to work with CMS on the issues discussed above or other topics that involve the academic medical center community. If you have questions, please contact Jessica Walradt at 202-862-6067 or jwalradt@aamc.org, or Lauren Kuenstner at 202-741-5516 or lkuenstner@aamc.org.

Sincerely,



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