

Via *Electronic Submission* (www.regulations.gov)

August 21, 2017

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

Re: (CMS-5522-P) Medicare Program; CY 2018 Updates to the Quality Payment Program

Dear Administrator Verma:

The Association of American Medical Colleges (AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's or the Agency's) *Medicare Program; CY 2018 Updates to the Quality Payment Program Proposed Rule (82 Fed Reg 30010)*. The AAMC is a not-for-profit association representing all 147 accredited U.S. and 17 accredited Canadian medical schools; over 400 major teaching hospitals and health systems, and 93 academic and professional societies. Through these institutions and organizations, the AAMC represents 160,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

The AAMC appreciates that CMS recognizes the need to transition slowly to the new framework for physician payment required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and its efforts to reduce clinician burden. We urge CMS to use the flexibility provided under the MACRA statute to create a longer transition period for the program and to reduce complexity and burden. While the rule includes proposals to reduce burden and complexity, the AAMC still has concerns with some of the components of the quality payment program (QPP), which we discuss in this comment letter. Although we are submitting extensive comments on this rulemaking, we anticipate that we will have additional feedback for CMS in the future when more data becomes available regarding the impact of the program in its entirety on eligible clinicians and their patients.

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

- **Risk Adjustment:** As appropriate, risk adjust outcome, population based measures, and cost measures for clinical complexity and sociodemographic factors.

- ***MIPS Identifiers:*** In addition to using the taxpayer identification numbers (TINs), national provider identifiers (NPIs), APM Identifiers, and Virtual Group Identifiers CMS should create an option for a MIPS subgroup identifier that would allow large multi-specialty groups to elect to have sub-groups under the same TIN assessed in the quality payment programs in a way that is meaningful.
- ***Quality Category:*** Continue to allow 90 days for reporting the quality performance category to allow additional time for clinicians to implement the quality measures in their practices and to understand the scoring method.
- ***Cost Category:*** Maintain the weight of zero percent for 2018 performance year. Prior to implementation of the cost category address risk adjustment and attribution concerns.
- ***Improvement Activities:*** Finalize the new improvement activities related to teaching, research, and continuing medical education and consider further expansion.
- ***Advancing Care Information:*** Finalize the proposal to allow the use of 2014 edition certified electronic health records technology (CEHRT) past 2017 and clarify the scoring methodology.
- ***Assessment dates for APM participation:*** Finalize the fourth assessment date of December 31 as it allows an eligible clinician who joins later in the year to be scored under the APM scoring standard. CMS should also expand the end of year date more broadly to include all MIPS APMs and to Advanced APMs.
- ***Nominal Financial Risk Definition:*** Do not increase the financial threshold in future years and eliminate the 50 clinician cap on medical homes.
- ***Qualifying Participant Threshold:*** Make it more feasible to achieve the qualifying APM thresholds by limiting the threshold calculations to those beneficiaries that live within the APM entity's primary service area.
- ***Other Payer Determination:*** Instead of requiring that eligible clinicians submit information for Other APM determinations, we recommend that CMS require the payers to submit this information to CMS about their models for approval.
- ***Medicare Threshold for Advanced APMs:*** CMS should consider reducing the Medicare threshold in the future to enable participants in these models to continue to qualify to receive the 5 percent bonus

Consideration of Unique Challenges for Large, Multi-Specialty Group Practices

As CMS continues to refine the Quality Payment Program, we urge CMS to consider the unique challenges posed by the QPP for large, multi-specialty group practices, such as those typically found in academic medical centers. These large multi-specialty practices face complex decisions about how to approach the MACRA Quality Payment Programs. In academic medical centers, faculty physicians frequently are organized under a single tax identification number (TIN) and treat the most vulnerable patients, those individuals who are poor, sick, and have complex medical needs.

Data from the Faculty Practice Solutions Center (FPSC), a joint product of Vizient and the AAMC, is helpful for an understanding of the breadth, depth and complexity of these large faculty practice groups. Recent FPSC data on 87 practice plans shows that they range in size from a low of 128 individual NPIs to a high of 4,319, with a mean of 989 and a median of 816.

FPSC also has data on over 70 adult and pediatric specialties which does not count the numerous subspecialties, such as burn surgery, cardiac surgery, and general surgery, to name a few. In some cases faculty practice plans are highly integrated and make decisions about quality improvement and care coordination as a single entity. In other instances such decision making occurs at the specialty level. In other words, these large groups are very different from small and solo physician practices. While they have learned how to report under the current quality programs, the choices under MIPS and APMs present a high level of uncertainty, complexity and risk for these large organizations.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

MIPS Eligible Identifier

CMS recognizes multiple identifiers that allow MIPS eligible clinicians to be measured as an individual or through a group's performance. CMS acknowledges that groups, including multi-specialty groups, have requested an option that would allow a portion of a group to report as a separate subgroup on measures and activities that are more applicable to the subgroup and be assessed based on performance of that sub-group. We are pleased that CMS intends to explore the establishment of group-related policies that would permit voluntary participation in MIPS at a subgroup level and create a new identifier.

The AAMC supports the CMS policy that allows providers to select whether they want to be assessed as an individual (TIN/NPI), group (TIN), APM participant identifier, and its proposal to add a virtual group identifier for 2018. **The AAMC encourages CMS to add a distinct subgroup identifier under MIPS, similar to the identifiers used for virtual groups or for Advanced Payment Models. This would allow a subset of physicians within a large TIN to form their own group for reporting and to select measures that are most appropriate for them.**

With evolving delivery and practice models, it is important for CMS to allow multiple options for identifying providers to assess eligibility, participation and performance under the MIPS program. Some faculty practices have multiple TINs for business or legal reasons but for all other purposes the physicians in the practice are part of the same group and want to be identified for reporting purposes under the same identifier. Use of a group MIPS identifier would enable these TINs to be measured as one group practice under the MIPS program. Some groups may be under a larger TIN but may want to break into sub-specialty components to allow for more accurate and meaningful measurement under the program. A sub-group MIPS identifier would be a mechanism for allowing smaller components under these large TINs to be measured separately from the TIN.

To allow participation in MIPS at a sub-group level, the AAMC recommends that CMS follow some of the policies set forth for virtual groups, which include:

- Establish a subgroup identifier

- Require the subgroup to make an election prior to the start of the applicable performance period under MIPS to be a subgroup.
- Request that a list of participants who would be part of the subgroup identifier be provided to CMS. A subgroup would submit each TIN and NPI associated with the subgroup, the name and contact information for a subgroup representative and a confirmation that each member of the subgroup is aware of their participation.
- Each MIPS eligible clinician who is part of the subgroup could be identified by a unique subgroup participant identifier which would be a combination of the subgroup identifier (established by CMS); 2) TIN and 3) NPI.
- Assess performance by a method that combines performance of all MIPS eligible clinicians in the subgroup across all four performance categories.

Depending on the practice, there are advantages and disadvantages to reporting under a subgroup MIPS identifier, an NPI, a TIN, or a combination. Under the MIPS program, the practices should be given the opportunity to assess the advantages and disadvantages and select whichever option works best.

Low Volume Thresholds

To reduce regulatory burden, beginning with the 2018 performance period, CMS proposes to increase the low-volume threshold. Specifically it would define individual eligible clinicians or groups who do not exceed the low volume threshold as an individual MIPS eligible clinician or group who, during the performance period has Medicare billing charges less than or equal to \$90,000 or provides care for 200 or fewer Part B-enrolled Medicare beneficiaries. CMS estimates that an estimated 585,560 clinicians would be excluded under the low-volume exclusion. Overall, CMS estimates that approximately one-third of eligible clinicians would be assigned a MIPS score in 2020 and the remaining clinicians will be ineligible or excluded from MIPS.

While the AAMC understands CMS's desire to reduce the participation burden under the MIPS program we are concerned about the impact this proposal may have on patient care. The program is designed to hold eligible clinicians accountable for the quality of that care; by increasing the threshold significantly fewer eligible clinicians will be participating. It would be beneficial for all physicians to be able to participate in a program that improves quality of care for their patients. **We recommend that rather than changing the threshold CMS develop approaches that enable broader participation in quality programs and provide education and resources to physicians so that they are able to be successful.**

Submission Mechanisms

In the 2017 QPP final rule, CMS also finalized that individual MIPS eligible clinicians and groups may only use one submission mechanism per performance category. We support the CMS proposal in the current rule to allow individual MIPS eligible clinicians and groups to submit measures and activities, as applicable, via as many submission mechanisms as necessary to meet the requirements of the quality, improvement activities or ACI performance categories.

Quality Performance Category

For the 2018 performance year, CMS proposes to set the quality performance weight at 60 percent to account for the proposal to weight the cost performance category at zero percent. In addition, the reporting period for the quality performance category would be a full year for the 2018 performance period.

Given the weight placed on the quality performance category, we recommend that CMS continue to allow reporting under this category for 90 days instead of a full year. We believe that CMS' goal in the early program years should be to ensure that participants can be successful under MIPS. Success requires participants to have an understanding of the quality measures, the data completeness criteria, the submission mechanism, and the scoring. Eligible clinicians need time to establish new workflows and understand tools to be able to successfully meet the performance requirements.

In addition, the AAMC encourages CMS to eliminate the requirement that one of the 6 measures reported be an outcome measure in the early years of the program. While we understand the importance of using outcome measures, there are still significant methodological issues related to risk adjustment that need to be addressed before requiring reporting of these measures. **Instead of requiring the reporting of outcome measures, we recommend that CMS award bonus points to eligible clinicians that report outcome measures.**

CMS should remove the 30- day hospital readmission measure from the program as it will also potentially penalize physicians who care for the most complex patients or those with low socioeconomic status. The impact of inadequate risk adjustment has been raised as a significant concern in the context of the hospital readmission quality program. This measure also is not appropriate as a physician quality measure because physicians may have limited control over sociodemographic factors which may be important contributors to a hospital readmission.

Cost Performance Category

CMS proposes to continue the zero percent weight for the cost performance category for the second year for the program due to concerns about clinicians' understanding of the cost measures and the need to further refine the measures. CMS notes that the MACRA legislation requires that beginning with the 2021 MIPS payment year (2019 performance year) it must assign a weight of 30 percent of the MIPS final score to the cost performance category.

For the 2018 performance year, CMS proposes inclusion of the total per capita cost measure and the Medicare Spend Per Beneficiary (MSPB) measure. CMS proposes not to include any episode-based measures. The Agency reiterates that in the future it intends to include new episode based measures for the 2019 performance period. We commend CMS for setting a weight of zero percent for year 2 of the quality payment program and for its decision not to include episode-based measures in year two of the QPP.

All Cost Measures Must be Appropriately Adjusted for Clinical Severity and Sociodemographic (SDS) Factors

Physicians at AMCs care for a vulnerable population of patients who are sicker, poorer, and more complex than many patients treated elsewhere. These factors generally mean that patients will require higher resource utilization. **AAMC remains concerned that the risk adjustment models for the cost measures (total per capita cost and MSPB) do not adequately address the impact of socio-demographic factors.** Recent reports from the National Academies of Science, Engineering and Medicine and Assistant Secretary for Planning and Evaluation (ASPE) have clearly acknowledged that SDS variables (such as low income and education) may explain adverse outcomes and higher costs. Without accounting for these factors, the scores of physicians that treat vulnerable patients will be negatively and unfairly impacted and their performance will not be adequately represented to patients. Differences in patient severity, rates of patient compliance with treatment, SDS, patient engagement, patient preferences for treatment approaches, and sites of care, can all drive differences in average costs. **Appropriate risk adjustment is essential so that differences in patient characteristics that are beyond a health care provider's control do not have an unfair impact on a provider's resource use performance score. The AAMC believes that CMS should appropriately adjust for SDS by incorporating identified factors into the risk adjustment methodology. As more is learned further refinements can be made in the future.**

Reliable, Valid Cost Measures Depend on Accurate Attribution

In addition, reliable and valid cost measures depend heavily on ensuring there is accurate attribution of patients to providers. MACRA requires that CMS develop codes that describe the various types of relationships between patients and providers to allow accurate attribution of patients to the appropriate providers. CMS proposed in the 2018 physician fee schedule rule to implement the reporting of the relationship modifiers on the claims forms on a voluntary basis beginning January 1, 2018. It will take time to gather accurate information from reporting of these modifiers and to determine whether it can be used for attribution. **Given the multiple moving parts under the cost category, including the need for risk adjustment, incomplete ICD-10 coding transition for episode groups, and pending patient relationship codes, the AAMC supports the continued weight of this category at zero and the decision not to include any episode-based measures until they are further developed.**

Develop Cost Measures for Use in Physician Offices Instead of Using Hospital Measures

Measures such as the MSPB were developed for use in hospitals. Many of the costs incurred in the hospital may be beyond the control of the physician. Instead of using this measure, CMS should develop and test resource use measures for physician practices.

Improvement Activities Category

CMS Should Not Require 50% of Practices Sites to Be Patient Centered Medical Homes

The MACRA legislation includes a provision specifying that a MIPS eligible clinician or group that is certified as a patient-centered medical home (PCMH) must be given the highest potential score for the improvement activity performance category. In the 2017 final rule CMS stated that

practices may receive designation of PCMH at a practice level and that TINs may be comprised of both undesignated practices and designated practices. To receive full credit as a PCMH, a TIN must include at least one practice that is a certified PCMH or comparable specialty practice. For the 2018 performance year and future years, CMS proposes that to receive full credit as a certified or recognized PCMH at least 50 percent of the practice sites within the TIN must be recognized or certified as a PCMH or comparable specialty practice. If a group is unable to meet the 50 percent threshold then the individual MIPS eligible clinician may choose to receive full credit by reporting as an individual for all performance categories. CMS states it has determined that the Comprehensive Primary Care Plus (CPC+) APM design satisfies the requirements to be designated as a medical home.

The AAMC is concerned that requiring at least 50 percent of practice sites within a TIN be recognized as a medical home could discourage participation by some physicians in the medical home models. Many large multi-specialty practices, such as faculty practice plans, have practice sites that are participating in medical home models. In underserved communities, at these sites large faculty practice plans are some of the only providers offering coordinately, culturally appropriate care. Large multi-specialty practices, such as academic medical centers, have a large number of specialists and therefore it is unlikely that 50 percent of the practice sites under their TIN would be medical homes. Excluding these medical homes from getting credit while other practices get full credit is likely to discourage practice locations from seeking this designation. We do not think that CMS's offers a reasonable alternative by stating that if the group does not meet the 50 percent threshold then the eligible clinician could receive full credit by reporting as an individual for all performance categories. For the physicians who are part of large multi-specialty groups, reporting as an individual would be very complex and burdensome.

CMS should not implement this policy. Once the agency establishes an alternative that allows a portion of a group under one TIN to report as a separate subgroup on measures and activities that are more applicable to that subgroup the Agency can consider whether to re-propose the policy. With evolving delivery and practice models, such as the medical home model, it is important for CMS to allow multiple options for identifying providers to assess eligibility, participation and performance under the MIPS program to encourage the development of these models.

CMS Should Finalize Proposed New Improvement Activities

For the second year of the Quality Payment Program CMS proposes to include several new improvement activities related to research, teaching, and participation in accredited quality improvement activities. We appreciate CMS' consideration of improvement activities that AAMC submitted this past year during the call for measures for inclusion in the program. Specifically, the AAMC strongly supports the inclusion of the following new improvement activities listed in Table F of the rule:

- MIPS eligible clinicians acting as preceptor for clinicians-in-training (such as medical students, physician assistants, nurse practitioners, or clinical nurse specialists) and accepting such clinicians for clinical rotations in community practices in small, underserved or rural areas. (Activity ID: IA_AHE_XX)

- Participation in federally and/or privately funded research that identifies interventions, tools, or processes that can improve a targeted patient population. (IA_PM-XX)
- Clinician Leadership in clinical trials, research alliances or community-based participate research (CPBR) focusing on minimizing disparities in healthcare access, care quality, affordability, or outcomes. (Activity ID: IA_AHE_XX)
- Completion of an Accredited Safety or Quality Improvement Program that addresses performance or quality improvement according to certain criteria. (IA-PSPA_XX)

The AAMC commends CMS for adding participation in federally and privately funded research and leadership in clinical trials. Teaching physicians regularly engage in research that is designed to improve health care outcomes, including improved quality and safety, by examining processes to improve care coordination and care redesign. Within the academic medical center, the research team may incorporate students, residents, and fellows which promotes the training of health care professionals in research designed to improve quality, minimize disparities, and improve care for targeted populations. The involvement of medical students and residents in these research efforts further increases their value, as the new generation of physicians learn about the value of this work. This research serves as the foundation for system-wide improved care management which advance the health and well-being of broad populations.

AAMC appreciates CMS' recognition of the importance of eligible clinicians acting as preceptors for clinicians-in-training. The proposed improvement activity could assist in the acceptance of a clinician-in-training in community practices where they can obtain experience working in underserved, rural areas and provide additional support in these communities.

We urge CMS to consider expanding this improvement activity to include medical school faculty physicians and teachers of other health care professionals. These faculty physicians and teachers of other health care professionals regularly engage with students, residents, and other allied health professionals to ensure that their education includes knowledge about improving quality of care, safety, and patient outcomes. Teaching in accredited programs assures a well-prepared and qualified workforce providing health care services, thereby improving patient care. The teaching, which includes treating the diverse populations that receive care in academic centers, promotes health equity. We recommend that the program and institution where the physicians and other health care professionals teach must be accredited to ensure that it is a sound institution and meets certain minimum standards in terms of administration, resources, faculty and facilities. This will provide for a better prepared health care workforce with the skills needed to provide high quality care.

The AAMC also strongly supports the improvement activity related to participation by physicians in accredited quality improvement activities that address performance improvement and /or quality improvement. Participation in these activities helps to improve the quality of care of patients. The AAMC supports programs approved by the Accreditation Council for Continuing Medical Education (ACCME), an organization that identifies, develops, and promotes standards of quality continuing medical education (CME) for physicians). It is important that the accredited CME provider defines meaningful physician participation in their

activity, include a mechanism for identifying physicians who meet the requirements, and provide participant completion information.

In addition, the AAMC supports the proposed changes to the Improvement Activity titled Practice Improvement that Engage Community Resources to Support Patient Health Goals (IA_CC_14, included in Table G of the rule). Specifically, we commend CMS for including screening patients for health harming legal needs in this improvement activity for screening and assessing patients for social needs within the care coordination category. For some patients, the social, financial, environmental or other problems in their lives have a deleterious impact on their health and are amenable to civil legal solutions. Screening for legal needs assists low-income and other vulnerable patients with receipt of public benefits (e.g. health insurance), food security concerns, disability issues, housing problems, employment instability, family matters, and additional problems that affect individual and community health. To reform the health care system and improve health, it is important to acknowledge and address the underlying causes that are barriers to health. There is a significant amount of unreimbursed clinician time, effort, and coordination needed to screen patients and develop referral pathways to community-based resources. Inclusion of this activity in the MIPS program is recognition of the time and effort involved in the provision of these important services.

Threshold for Improvement Activities

In the 2017 QPP final rule, CMS clarified that all MIPS eligible clinicians reporting as a group will receive the same score for the improvement activities performance category if at least one clinician in the group performed the activity for a continuous 90 day period. While CMS is not proposing any changes to this policy, it requests comments on whether it should establish a minimum threshold (e.g. 50 percent) of the clinicians (NPIs) that must complete an improvement activity for the entire group (TIN) to receive credit for the activity. CMS also requests comments on recommended minimum threshold percentages and whether it should establish different thresholds based on the size of the group.

We are concerned that such a high threshold could discourage participation in improvement activities by some physicians, particularly those in large, multi-specialty group practices, if they are not able to receive credit for those activities. In contrast, physicians that are not part of a large practice may receive full credit for performing the same improvement activity. Physicians in faculty practice plans participate in numerous improvement activities with the goal of expanding practice access, population management, care coordination, improving patient safety, improving equity. These activities which could involve population management, data analytics, care coordination, and other areas can be very expensive in terms of cost and staff time. The investment in these activities should be recognized by providing credit under the MIPS program. Because there are so many different specialties and practice locations in faculty practices, it can be difficult to ensure that 50% of the physicians under the TIN perform the same improvement activity for 90 days. For example, some specialists may be involved in improvement activities related to maintenance of certification improvement activity while others, such as primary care providers, may be involved in population health activities.

Advancing Care Information

CMS Should Finalize the Proposal to Allow 2014 or 2015 CEHRT

The AAMC supports the CMS proposal that for the 2018 performance period MIPS eligible clinicians may use EHR technology certified to either the 2014 or 2015 certification criteria, or a combination of the two. This extension is important since there is still a lack of products certified to the 2015 edition. This will also enable vendors to focus on incorporating the new MIPS measures, including the quality measures, which are proposed to have a full-year performance period in 2018. The Association also supports the proposal to offer bonus points under the ACI performance category for MIPS eligible clinicians who report the ACI Objectives and Measures for the 2018 performance period using only 2015 edition CEHRT.

The AAMC encourages CMS to further simplify the ACI scoring methodology. The ACI scoring system, which is comprised of both performance and base scores, remains extremely complex and creates significant barriers to achieving CMS' goals of a simplified program. The scoring methodology is likely to be confusing for clinicians during the first years of the program, causing them to inadvertently fail the entire ACI category. Furthermore, the opportunity for clinicians to receive bonus percentage points is helpful but also is confusing. The AAMC recommends that CMS provide clinicians with additional guidance and tools to help them avoid unintentional harm in their ACI performance score.

The AAMC supports CMS' proposal to require reporting under ACI for a 90 day period.

Facility –Based Scoring

In the rule, CMS proposes a new scoring option for the quality and cost performance categories that allows facility-based MIPS eligible clinicians to be scored based on their facility's performance. For the 2020 payment year CMS proposes to include all the measures adopted for the FY 2019 Hospital VBP Program on the MIPS list of quality and cost measures. CMS also seeks to limit the applicability to those MIPS eligible clinicians with a significant presence in the hospital. The proposed definition would require that a MIPS eligible clinician is facility-based as an individual if the clinician furnishes 75 percent or more of the covered services in the inpatient hospital setting or emergency room. For a group to be facility-based, 75 percent or more of the MIPS eligible clinicians under the TIN would need to be considered facility-based as individuals. Under the proposal, eligible clinicians would elect to be facility-based.

Overall, the AAMC is supportive of the facility-based scoring proposal as we believe it can reduce reporting burden on facility-based MIPS eligible clinician's by leveraging existing quality data sources and better aligning the incentives between facilities and the MIPS eligible clinicians who provide services there. CMS should consider expanding this approach for physicians who are employed in other facilities, such as skilled nursing facilities. With regard to the clinicians in the hospital setting, we support the use of the Hospital VBP program as the method for determining quality and cost for these clinicians and we strongly recommend that the facility-based measurement process be voluntary.

Many physicians who would be considered facility-based provide care in multiple different hospitals. For example, a radiologist maybe be working in several hospitals. The AAMC asks CMS to clarify which Hospital VBP Program score would apply to eligible clinicians who practice in more than one hospital.

While we believe that the facility-based scoring can benefit some hospital-based physicians, as proposed it will most likely not be feasible for facility-based physicians in large multi-specialty practices that bill under one TIN to select this scoring option due to the 75% threshold. We encourage CMS to develop other mechanisms for facility-based physicians in these large practices to elect to be scored under this approach. One option would be to allow a portion of the group under one TIN, such as the facility-based clinicians to report as a separate subgroup on measures and activities.

Considerations for Social Risk Factors

In the rule, CMS states that it understands that social risk factors (referred to as socioeconomic status) play a major role in health and that one of the Agency's main objectives is to ensure all beneficiaries, including those with social risk factors, receive high quality care. The Agency also seeks to ensure that the quality of care furnished by providers is assessed fairly under their programs.

Specifically, CMS seeks public comment on whether MIPS should account for social risk factors, and if so, what method or combination of methods would be most appropriate for accounting for those factors. In addition, CMS requests comment on which social risk factors might be most appropriate for stratifying measure scores and/or potential risk adjustment of a particular measure.

Most outcome measures in the quality performance category and cost measures are affected by sociodemographic status (SDS) factors, which are beyond the control of the physician. Physicians in academic medical centers tend to disproportionately treat disadvantaged and vulnerable patient populations and therefore could be unfairly penalized by performance programs that do not have adequate SDS adjustment. The AAMC remains concerned about the lack of application of validated risk-adjustment of outcome measures and cost measures for socioeconomic risk factors.

Over the past several years, a substantial amount of literature has recognized the impact of SDS factors on patient outcomes.^{1,2} Recent reports released by the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the National Academy of Medicine (NAM) on accounting for social risk factors in the Medicare performance programs have provided evidence-based confirmation that accounting for patients' sociodemographic and other social risk factors is critical in validly assessing the quality of providers. The reports demonstrate that providers caring for large numbers of disadvantaged patients are more likely to receive penalties in the performance programs and that the lack of SDS adjustment can worsen health care disparities because the penalties divert resources away from providers treating large proportions of vulnerable patients. The failure to account for SDS variables also is misleading and confusing to patients, payers, and policymakers because it

¹ Michael Barnett, MD, et al. *Patient Characteristics and Differences in Hospital Readmission Rates*. *JAMA*, 2015. Retrieved from: <http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2434813>

² Jianhui Hu, et al. *Socioeconomic status and readmissions: evidence from an urban teaching hospital*. *Health Affairs*, 2014. Retrieved from: <http://content.healthaffairs.org/content/33/5/778.full>

shields them from important community factors that contribute to poor health outcomes. Finally, as noted by ASPE, the cumulative effect of the penalties across the Medicare performance and penalty programs could significantly hinder the work of those institutions that disproportionately serve beneficiaries with social risk factors.³ Both reports clearly show that there are implementable mechanisms by which SDS data elements can be incorporated into quality measurement today. **The AAMC urges CMS to incorporate the recommendations below to begin accounting for SDS factors as the first step toward ensuring that all providers are assessed on an even playing field:**

- Require measure developers to test a range of national-level sociodemographic data elements, identified in the ASPE⁴ and NAM⁵ reports, into the risk adjustment methodology of accountability metrics. Both reports discuss in detail data elements that are publicly available and could be immediately tested to determine whether an empirical relationship exists between SDS and the measure's outcomes. Such elements could include income, education, neighborhood deprivation, and marital status.
- Consider stratifying certain measures by dual eligible status or other nationally available data elements.
- Implement demonstration projects to encourage eligible clinicians to collect SDS data through their electronic health records (EHR). These elements could be used to supplement the claims data already captured by CMS to greatly improve the measure's risk adjustment methodology. It is essential that CMS include vendors in these discussions.
- Where meaningful and comprehensive neighborhood level SDS-data currently exist, CMS should encourage empirical tests of quality metrics adjusted for those factors to assess the impact of the adjustments on local provider performance metrics. Based on the results of these tests CMS and other agencies will be able to prioritize the national collection of data that are most essential for valid risk adjustment methodologies.

CMS may want to consider stratifying measure benchmarks to ensure accurate comparison among physicians. Some subspecialties or types of practices treat higher risk patients so comparison across all physicians who perform a particular procedure may not be accurate in terms of cost or quality comparisons. Differences in regions or SDS factors could also impact the scores on measure. Site of service may also have an impact on the performance measures. For example, in an inpatient hospital, patients are more likely to have significant comorbidities that make it essential to compare costs and quality for physicians in this setting only to that of other physicians treating a similar patient population in the same or a similar site of service.

Complex Patient Bonus

For 2018 CMS proposes to address the impact that patient complexity (e.g. health status, medical conditions, and social risk factors) may have on final scores by giving a bonus based on the

³ "Office of the Assistant Secretary for Planning and Evaluation." *Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Program*. December, 2016. Pg. 92 Retrieved from <https://aspe.hhs.gov/system/files/pdf/253971/ASPESESRTCfull.pdf>

⁴ *ibid*

⁵ "National Academies of Medicine." *Accounting for Social Risk Factors in Medicare Payment: Criteria, Factors, and Methods*. 2016. Retrieved from <https://www.nap.edu/download/23513#>

average HCC risk score. The Agency proposes that the complex patient bonus cannot exceed 3 points. AAMC applauds CMS for recognizing the need to provide a bonus for treating complex patients. Physicians at AMCs care for a vulnerable population of patients who are sicker, poorer, and more complex than many patients treated elsewhere. As a result, they may require higher resource utilization and there may be an impact on quality scores. Until further information is available on the most appropriate factors to use for risk adjustment, we would agree with the use of the HCC risk score for this purpose. **However, CMS should provide a bonus amount that is greater than 3 points but not less than the 5 points that is the bonus for a small practice. This amount seems inadequate and will have a minimal impact on the overall score which is based on 100 points.**

ELIGIBLE CLINICIANS PARTICIPATING IN MIPS APM REPORTING

MIPS eligible clinicians participating in certain APMs receive a score under MIPS that is associated with the APM. CMS generates a MIPS score by aggregating the scores for eligible clinicians who are participating in the MIPS APM to the level of the APM entity. The MIPS score would apply to all MIPS eligible clinicians in the APM entity. MIPS data submission requirements should be reduced to enable MIPS eligible clinicians participating in APMs to focus on care delivery redesign rather than reporting requirements.

CMS Should Allow Facility-Led APM Entities to Qualify as MIPS APMs.

The AAMC recommends that CMS make changes to enable more clinicians participating in APMs to report under MIPS as an APM Entity by allowing facility-led models to be scored under the program. Physicians cannot be considered ancillary to these models – they are central. It is important to encourage eligible clinicians to participate in the facility led-models such as BPCI and CJR, which have been effective in reducing costs and improving quality. These models rely on robust physician participation to guide their clinical success, and reimbursement for physician services is included in the price of the bundle. Physician participation should be evaluated and rewarded as such. If the APM scoring standards do not apply, clinicians may be discouraged from participating in these models in the future. Most facilities maintain lists of clinicians who are participating in their models, or they could be required to do so if they want their models to qualify as APMs. This is a minor operational issue that CMS could resolve by working with these facilities to identify a method to obtain these lists so that the clinicians can be uniquely identified for MIPS scoring purposes.

CMS should recognize clinicians who participate in APMs as affiliated practitioners, i.e., those who are in a contractual relationship with the APM entity based in part on supporting the APM's quality or cost goals. This would be consistent with CMS's recognition that these affiliated practitioners could be "qualified APM participants." According to CMS, the APM scoring standard would not apply to MIPS eligible clinicians involved in APMs that include only facilities as participants (such as the Comprehensive Care for Joint Replacement Model). Participants in these models would need to be assessed under the generally applicable MIPS data submission requirement.

Assessment Dates for Inclusion of MIPS Eligible Clinicians in APM Entity Groups Under the APM Scoring Standard

In the 2017 rule CMS finalized that eligible clinicians who are on a Participation List on at least one of three assessment dates (March 31, June 30, and August 31) would be considered part of the APM Entity group. Eligible clinicians who are not on the Participation List on one of these 3 dates would need to submit data to MIPS and have their performance assessed either as an individual or a group under the general MIPS program. CMS proposes that beginning in 2018, a fourth assessment date of December 31 will be added to identify MIPS eligible clinicians who participate in a full TIN APM, such as a shared savings program model).

The AAMC support that addition of the fourth assessment date as it allows an eligible clinician who joins later in the year to be scored under the APM scoring standard. However, we recommend that CMS use the fourth assessment date more broadly for all MIPS APMs and also for Advanced APMs. There are many scenarios in which MIPS eligible clinicians change TINs, use more than one TIN to bill Medicare, or change their APM participation status during a performance period. Under current rules, if clinicians join an APM after August 31, they would need to proactively submit other quality measures not required by the APM in order to avoid a negative adjustment, a requirement that is overly burdensome and could discourage the addition of new eligible clinicians to the APM later in the year. CMS expresses concern that in some APMs eligible clinicians would inappropriately leverage the fourth assessment date to avoid reporting and scoring under the generally applicable MIPS scoring standard. While we understand CMS' concern, we believe that there are other steps that CMS could take to address the concerns about "gaming" of the system.

Other MIPS APMs

Due to concerns about operational readiness CMS reweighted the quality category score to zero for performance year 2017 for "Other APM Entities" (Oncology Care Model, CPC plus model, and Comprehensive ESRD Care Model). To be consistent with shared savings ACOs and Next Generation, CMS proposes to set performance weights for the "Other APMs" in 2018 as follows: Cost 0 percent, Quality 50 percent, Improvement Activities 20 percent and ACI 30 percent. Beginning with the 2018 performance year, CMS proposes to adopt quality measures for use by Other MIPS APMs under the APM scoring standard.

CMS proposes to establish a separate MIPS final list of quality measures for each Other MIPS APM that would be the quality measure list used for purposes of the APM scoring standard. The Agency states that it would score only measures that: 1) are tied to payment; 2) are available for scoring near the close of the MIPS submission period, 3) have a minimum of 20 cases available for reporting, and 4) have an available benchmark.

CMS proposes that the benchmark score used for a quality measure would be the benchmark used in the MIPS APM for performance based payments when a benchmark is available. If the APM does not produce a benchmark score, it would use the benchmark score for the measure that is used for the MIPS quality performance category generally (outside of the APM scoring standard) provided that the measures specifications are the same. CMS states that for

benchmarks that are pay for reporting will be considered to be lacking a benchmark and will be treated as such.

In the rule, CMS proposes a list of quality measures for the oncology care model in Table 14. **The AAMC recommends that CMS maintain the quality measure weight at zero percent in the 2018 performance period for the Oncology Care Model (OCM). We are concerned that this model is still in its early years and therefore it is premature to score participants based on performance on the quality measures.** For year 2 of the program, CMS should continue to weight ACI at 75% and improvement activities at 25% for the oncology care model.

The majority of the quality measures in the OCM are pay for reporting for episodes that end in the first half of 2018, which is an indication that CMS recognizes it is not appropriate to judge participants on their performance in the early phases of implementation. Since the OCM is a pilot, the Centers for Medicare and Medicaid Innovation constantly is adjusting the program rules and requirements in response to participant and stakeholder feedback, including making changes to the measure specifications to fix challenges with the program.

Furthermore, many OCM practices are reporting low volumes for a subset of the quality measures, For example, academic medical centers with over 1,000 OCM episodes per year have shared that across a six month measurement period they identified only a small subset of patients (less than 20 to approximately 50) across their Medicare and commercial populations that fit the measure denominators for OCM-7, 8, 9, and 10. Small practices would have an even lower volume of cases.

Because the majority of OCM quality measures are currently pay for reporting and the number of cases available for reporting on some of the quality measures is so low, it is unlikely that this model would have accurate benchmarks for the quality measures. While some of the measures used in the model are included under the general MIPS program, the AAMC does not think it would be appropriate to use benchmarks derived from the general MIPS program to measure performance under a model that involves care for a very specific population of patients with cancer.

We recognize the importance of assessing quality in the oncology care program. However, it is important to reduce burden to enable MIPS eligible clinicians participating in models, such as OCM, the time to focus on care delivery redesign, particularly when the model is in its early stages. In addition, OCM practices and their physicians are making significant investments in quality improvement. Participation in OCM requires that practices fulfill six overarching “practice requirements” that center around enhanced care coordination. These include:

- Providing 24/7 access to an appropriate clinician;
- Providing the core functions of patient navigation;
- Documenting a comprehensive care plan that includes advance care planning, psychological support tools, and, as appropriate, survivorship plans; and
- Using therapies consistent with national recognized clinical guidelines.

ADVANCED ALTERNATIVE PAYMENT MODELS

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

Nominal Amount Standards for Advanced APMs

Eliminate the 50 Clinician Cap on Medical Homes

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

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

Generally Applicable Revenue-Based Nominal Amount Standard

The AAMC supports CMS' proposal that the generally applicable revenue-based nominal amount standard remain at 8 percent of the average estimated total Medicare Parts A and B revenue of providers participating in APM entities for the 2019 and 2020 Medicare QP performance periods. CMS seeks comment on the amount and structure of the revenue-based nominal amount standard for 2021 and later. To preserve stability and clarity in the program we believe it is important to maintain the standard at 8 percent for the next 3 years at a minimum.

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

While AAMC supports defining financial risk as a percentage of the APM Entity's total Part A and B revenues, **we recommend that CMS exclude Part B drug revenues from the calculation of this amount.** The majority of the time, payments for these drugs are treated as pass through payments to cover the cost of acquiring the drug. For some physicians, such as oncologists, the revenues and costs for these drugs are significantly higher than the revenues used to pay for physician's professional services, thereby placing the practice a high risk of losing most of their revenues derived from professional services.

Qualifying and Partial Qualifying APM Participants

CMS establishes and maintains an APM participant database that will include all of the MIPS eligible clinicians who are part of the APM entity. CMS determines which clinicians are participants in the APM entity group for purposes of making QP determinations three times during the year: March 31, June 30, and August 31. **While we support the use of these snapshot dates, we encourage CMS to consider the addition of December 31 as another date to determine APM participation.** This would be consistent with CMS' proposal in this rule to include a fourth snapshot date of December 31 for scoring purposes under MIPS for shared savings program participants.

Academic medical center clinicians relocate with some frequency for a variety of personal and professional reasons. The current policy would require any clinicians that join the APM after August 31 to report separately under the MIPS program. This creates additional complexity and burden for the physician as they would need to identify and report separate quality measures and improvement activities.

Other Payer Advanced APMs: financial risk standards

CMS proposes to add a revenue-based nominal amount standard to the generally applicable nominal amount standard for Other Payer Advanced APMs that is parallel to the standard for the Medicare Advanced APMs. Specifically, the Agency proposes that the standard would be met if the total amount that an APM entity owes the payer or forgoes is 8 percent of the total combined revenues from the payer of providers in participating APM entities. CMS also proposes that the Other Payer Advanced APM would need to meet either the benchmark based nominal amount standard or the revenue-based standard. We support this proposal as it will expand opportunities for other payer arrangements to qualify as Advanced APMs. In addition, setting the same financial risk requirements for Other Payer Advanced APMs that is set for Medicare Advanced APMs will help to facilitate physician involvement in other payer models. It is difficult for

physicians to stay abreast of different requirements regarding payment structures, quality metrics, and other components of these programs.

All Payer Combination Option

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. To be considered an Other Payer Advanced APM, the APM must meet criteria for CEHRT use, MIPS-comparable quality measures, and financial risk. In this rule, CMS proposes two processes, Payer Initiated and Eligible Clinician Initiated, for assessing whether the specific payment arrangement for these models meet the Other Payer Advanced APM criteria. These processes involve either the payer or the eligible clinician submitting detailed information to CMS regarding the arrangement. The payers can decide voluntarily to submit the information to CMS for a determination and there is no obligation for the payer to notify the eligible clinicians of their submission or the CMS determination. CMS also proposes that the All-Payer QP determinations be made at the individual clinician level.

The AAMC has significant concerns with the approach to the All Payer combination. It presents major operational challenges for eligible clinicians as compared to the Medicare option. Reporting the information to CMS would be extremely burdensome for the eligible clinicians, and is further compounded by the proposal to make the determination on an individual clinician level. For each individual clinician to submit this detailed information to CMS about the other alternative payment models would be very difficult, time consuming, and would require unnecessary duplicative effort on the part of each clinician. There also could be constraints in their contractual arrangements with the payer that limit their ability to share some of the information.

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 about their models for approval. The payers are in a much better position to share this information about their models. It is impractical and duplicative for multiple eligible clinicians that participate in the same Other Payer Alternative Payment Model to separately submit this information to CMS about the arrangement for approval. Even if CMS believes that it does not have the authority to require payers to make this submission, the Agency should be able to strongly encourage payers to do so as it would be an important way for payers to increase physician participation in their Alternative Payment Models. In addition, we recommend that CMS require the Other Payers to notify the eligible clinicians who are participants in the model that they have submitted the information to CMS and whether their model has been determined by CMS to meet the criteria.

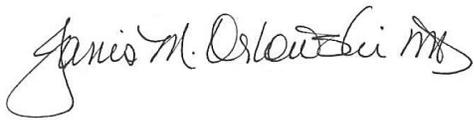
We have significant concerns about the operational challenges associated with making determinations under the All Payer Combination Option, which could make it impossible to achieve the thresholds under this option. In addition, we are concerned about the ability of participants in alternative payment models to meet the increased Medicare payment threshold of 50 percent in future years. The AAAMC understands that the payment thresholds are in statute but recommends **that CMS find ways to assist eligible clinicians in obtaining the Medicare**

threshold. Without significant assistance, eligible clinicians may be discouraged from participating in the Advanced Payment Models.

CONCLUSION

Thank you for your consideration of these comments. If you have any questions concerning these comments, please feel welcome to contact Gayle Lee, Director of Physician Payment Policy and Quality at 202-741-6429 or galee@aamc.org or Ivy Baer 202-828-0499 or ibaer@aamc.org.

Sincerely,

A handwritten signature in black ink that reads "Janis M. Orlowski MD". The signature is fluid and cursive, with the letters "J", "M", and "MD" being particularly prominent.

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

cc:

Ivy Baer, AAMC
Gayle Lee, AAMC