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Via Electronic Submission (www.regulations.gov)

March 28, 2016

Mr. Andrew Slavitt
Acting 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-1644-P) Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations; Proposed Rule

Dear Acting Administrator Slavitt:

The Association of American Medical Colleges (AAMC or Association) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS' or the Agency's) proposed rule entitled *Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations*, as published in the Federal Register February 3, 2016. The AAMC is a not for-profit association representing all 145 accredited U.S. allopathic medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

The AAMC supports alternative payment model (APM) programs, 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. AAMC is also a facilitator-convener for the Bundled Payments for Care Improvement (BPCI) initiative for 30 hospitals and 19 health systems. In a study published in *Health Affairs* in March 2016,

researchers found that teaching hospitals have a higher likelihood of belonging to an ACO than non-teaching hospitals.[1]

The MSSP program has the potential to lower cost, promote care coordination and improve quality of care. While the MSSP program currently has 434 ACOs, sustained and increased participation will depend on potential financial opportunities being adequate to support the investments needed to improve quality, and coordinate care. We encourage CMS to refine the program so that it will be sustainable in the long-term.

The AAMC and several other stakeholders, including physicians, hospitals, medical group practices, and nearly all existing MSSP ACOs, worked together on a joint letter that outlines recommendations regarding the ACO benchmark proposed rule. In this letter, the AAMC highlights some specific recommendations regarding the benchmark that would help to ensure continued participation by Academic Medical Centers in the ACO shared savings program and future success of the program.

In this letter, the AAMC provides the following key recommendations:

- Phase in a blend of historical and regional costs in the reset benchmarks. Identify ways to mitigate the negative impact on ACOs that would be harmed by the reset benchmarks, such as stop-loss approaches.
- Allow maximum flexibility and choices to ACOs regarding application of the new benchmark methodology. This would include allowing some ACOs to begin new agreements with rebased regional benchmarks earlier, and allowing a more gradual phase in period for other ACOs.
- Revise the regional service area definition so that it includes counties of residence in which more than 1% of ACO assigned beneficiaries reside.
- Remove ACO-assigned beneficiaries from the regional service area reference population so that an ACO's performance is compared only to the fee for service population.
- Continue the exclusion of IME and DSH payments from an ACO's benchmark and performance year calculations.
- Add portions of the savings that the ACO achieves in the previous agreement back into the benchmark for subsequent agreements.
- Change ACOs risk score methodology to include more complete and up to date risk adjustment that better reflects the clinical complexity and patients characteristics, such as socioeconomic status, of the ACO's population. This includes adjusting the ACO benchmarks annually for continuously assigned beneficiaries.
- Shorten the reopening time frame for revised initial determinations to 2 years and hold ACO's harmless for technical errors made by CMS in their shared savings calculations.
- Allow ACOs to form on the basis of partial tax identification numbers as a means to incentive them to take on two-sided risk.
- CMS should monitor the impact on continued participation in the ACO shared savings program by providers, including Academic Medical Centers, and make refinements as

[1] H. Colla, V. Lewis, E. Tierney et al., "Hospitals Participating in Accountable Care Organizations Tend to Be Large and Urban, Allowing Access to Capital and Data," Health Affairs, March 2016 35(3):431–39. ____

needed to ensure sustained participation.

Incorporate Regional Expenditures In the ACO's Rebased Benchmark

In the rule, CMS discusses in detail its proposal to change the methodology for rebasing the benchmarks used in the Medicare Shared Savings Program for ACOs that decide to continue to participate after their first three year agreement ends. Currently, CMS uses a benchmarking method that measures the ACO's effectiveness in lowering expenditures for its assigned beneficiaries against a benchmark that is determined based on the ACO's historical costs of treating this group of beneficiaries. At the beginning of the 3 year agreement, CMS sets the average per capita historical benchmark which is based on Part A and Part B Medicare fee for service expenditures for beneficiaries who would have been assigned to the ACO in each of the 3 years prior to the start of the ACO agreement. If an ACO's spending is below the benchmark, the ACO can share in the savings. After the 3 years, if the ACO decides to enter into a second 3 year agreement with Medicare, CMS resets the benchmark based on the ACO's specific historical spending.

CMS proposes to modify the method for rebasing and updating ACO historical benchmarks to incorporate regional expenditures when an ACO renews its participation agreement for second and subsequent agreement periods. Specifically, the proposal would gradually incorporate regional fee for service cost data in the benchmark along with a portion of the ACO's historical cost. Initially, regional expenditures would be weighted 35% and historical expenditures would be weighted 65%. This would apply to ACO's that begin their second agreement period in 2017. In the third agreement period (which would be in 2020 for some ACOs), CMS proposes that regional expenditures would be weighted 70% and historical 30%. The goal is to measure and ACO's performance against providers in the same market instead of measuring the ACO based on its own past performance.

Creating the right benchmarks for ACOs is a key to success for ACO participants and is essential for keeping those participants in the program. The current benchmark methodology could adversely impact ACOs that succeed in reducing their costs by adversely affecting their future benchmarks.

For this reason, the AAMC is generally supportive of CMS incorporating a portion of regional cost data in in the benchmark. However, we think it is important not to rely exclusively on regional cost data as there could be ACOs that have complex patient populations that would necessitate use of a greater portion of historical costs in the benchmark. **Therefore, we support the concept of using a blend of historical and regional cost data to establish ACO benchmarks that would be phased in more gradually than the CMS proposal. While some ACOs will benefit from the new methodology for resetting benchmarks, others will be negatively impacted. CMS should identify ways to mitigate the negative impact on the ACOs that would be harmed by this change so that they are not forced to leave the MSSP program. This could include stop-loss approaches that set limits on the magnitude of any reductions in the benchmark or changes to other policies, such as more complete and up to date risk adjustment. If CMS adopts this new benchmark methodology, CMS should monitor the impact on continued participation in the ACO**

shared savings program by providers, including Academic Medical Centers, and make refinements as needed to ensure sustained participation.

Allow Different Approaches to Transition to New Benchmark Methodology

CMS proposes to phase in the regional cost data over multiple agreement periods. It would first impact ACOs that begin their second or subsequent agreement period in 2017. ACOs that began an agreement in 2016 would need to wait until 2019 to have regional data incorporated. Some ACOs that would benefit from incorporating regional expenditures in the benchmark may want to transition more quickly, while those that would be harmed would want a gradual change. **CMS should provide maximum flexibility and choices to ACOs regarding application of the revised benchmarking methodology.** AAMC recommends that CMS make the following choices available to ACOs:

- Allow ACO's that renewed in 2016 to have the option to begin new agreement periods with rebased benchmarks that include a regional component in 2017 instead of making them wait until 2019.

- For ACO's that may have a downward swing in their benchmark, allow a more gradual phase-in to the new methodology. For example, CMS could apply 10% regional cost data in performance year 1, 20% in year 2 and 35% in year 3. For this group, CMS should also set a limit on the amount of reduction that would occur in the benchmark so that the ACO does not sustain significant losses due to the new methodology.

- Provide ACO's in their initial agreement the option of immediately incorporating regional expenditure data in their benchmark or choosing to use historical data. For these ACO's there could be a gradual phase in of apply 10% regional cost data in performance year 1, 20% in year 2 and 35% in year.

Regional Service Area Should Include Counties of Residence Where More than 1% of Assigned Beneficiaries Reside

CMS proposes to define the ACO's regional service area based on counties of residence of the ACO's assigned beneficiary. There could be multiple counties included in the ACO's regional service area. CMS proposes that the ACO's region would include any county where **one** or more beneficiaries assigned to that ACO reside. CMS would weight the county level FFS costs by the proportion of the ACO's assigned beneficiaries in the county. Therefore, if only one beneficiary resides in the county, the county would have a very small weight in the calculation of the benchmark. **While we support basing the regions on counties, in which the ACO's beneficiaries resides, we believe that the threshold of one beneficiary is too low.**

The AAMC has heard from multiple AMCs that participate in ACOs that it is common for them to have assigned beneficiaries that reside far away from the ACO's general service area. Academic medical centers tend to be destinations for specialized care, drawing patients from around the country and the world with specific and complex health care needs. If CMS adopts this threshold, ACOs with Academic Medical Centers could have many different regions of the

country included in their benchmark calculation even if they care for only one patient who resides in a particular county. **We recommend CMS increase the threshold to one percent of the ACO's assigned beneficiary population, as CMS has done in the Physician Group Practice Demonstration, for example.** As proposed, CMS should continue to weight the county level FFS costs by the proportion of beneficiaries assigned to that county. This will reduce complexity and result in a better reflection of the ACO's general regional service area.

Remove ACO-Assigned Beneficiaries From the Regional Service Area Population Calculation

In determining the regional expenditures for resetting the benchmark, CMS proposes to calculate fee for service costs for all assignable beneficiaries including those who have been assigned to the ACO. CMS states that "assignable beneficiaries, are Medicare FFS beneficiaries that received at least one primary care visit from any Medicare primary care physician or physician with a primary care specialty designation for purposes of ACO assignment during the 12 month assigned period window.

AAMC supports limiting the beneficiary population to "assignable beneficiaries." Beneficiaries who have not received one primary care service during the time frame should be excluded as they would inappropriately lower the expenditures against which the ACO would be compared. **However, i**f **the ACO-assigned beneficiary population remains in the calculation of expenditures, the regional cost data could be skewed by the ACO's efforts to coordinate care and reduce expenditures for the ACO assigned beneficiaries**. **Therefore, we urge CMS to remove ACO-assigned beneficiaries from the regional service area reference population so that ACO's performance is compared relative to the fee for service population instead of the ACO population.**

CMS should Continue Exclusion of IME, DSH, and Uncompensated Care from Benchmarks

The AAMC continues to strongly support the exclusion of IME, DSH and uncompensated care payments from an ACO's benchmark and performance year calculations. We are pleased to see in this rule CMS remains committed to its policy of excluding these add-on payments. This policy is necessary to protect beneficiary access to necessary care at teaching hospitals. The Medicare program has long recognized the higher costs associated with the important societal roles of teaching hospitals and has provided DGME, IME, and DSH payments to help offset these costs. In addition to training future physicians and other health care professionals, teaching hospitals treat the sickest and most complex Medicare patients. They have higher case mix indices and treat a disproportionate share of outlier cases. These institutions also receive the majority of transfers from other hospitals when patients need more sophisticated and diagnostic and treatment services than other providers can deliver.

To include these policy add-on payments in ACO benchmarks would give ACOs a strong financial incentive to find savings by steering patients away from teaching hospitals rather than savings through redesigned and improved care which are the goals of the program. Continuing to exclude IME, and DSH payments from the benchmark and performance calculations will help

ensure that decisions by ACOs will be based on *clinical* determinations that are in the best interests of the patient.

CMS Should Continue to Account for Savings in Rebased Benchmarks

Currently, CMS adjusts rebased historical benchmarks to recognize savings in expenditures that a successful ACO achieves during its first agreement period. Specifically CMS adds a portion of the savings from the previous agreement into the rebased benchmark to encourage ongoing participating in the program. CMS proposes in this rule to changes its policy so that savings achieved in the prior agreement period would not be added to the rebased benchmark.

We are concerned that this proposal would unfairly penalize organizations that invest in care coordination, quality improvement, and lower expenditures. To reverse the policy to add the savings back into the benchmark once success is achieved would discourage ongoing participation in ACOs. CMS's rationale is that incorporating regional expenditures would lessen the impact of removing this adjustment. However, there are ACOs with regional spending benchmarks that are less than their historical benchmarks. The detrimental impact of the change to regional expenditures for this group of ACOs would be exacerbated by the decision not to recognize savings in the benchmark. **Therefore, the AAMC urges CMS to continue to add the savings back into the benchmark of subsequent agreements.**

Adjust ACO Risk Scores to Reflect Actual Beneficiary Complexity

In the rule, CMS proposes to adjust for differences in health status between an ACO and its regional service area in a given year when determining the regional adjustment to the ACO's rebased historical benchmark. CMS believes this will account for differences in health status between the ACO's assigned population and the broader FFS population in the ACO's regional service area. **Regardless of whether the benchmarking methodology is regional or historical, there is a need for more complete and up to date risk adjustment to better reflect the clinical complexity and patient characteristics of their ACO's population, including socioeconomic status.**

CMS notes that it will continue to use CMS-HCC risk scores for the ACO's assigned beneficiary population in risk adjusting the historical benchmark at the start of the agreement period. CMS discusses its policy of taking into account changes in severity and case mix for newly assigned beneficiaries but limiting adjustment to continuously assigned beneficiaries to demographic factors**. We strongly recommend that CMS change its policy so that an ACO's benchmarks are adjusted annually for continuously assigned beneficiaries when there is a genuine change in health and risk status of their patient population.** ACO's who have made genuine improvement in their patients see a downward adjustment if the patients get healthier, but no upward adjustment if their health status worsens**.**

This imbalanced risk adjustment methodology disadvantages all ACO's but disproportionately affects ACO's led by academic medical centers. AMCs treat sicker and more complex patient populations. These patients are more likely to have multiple comorbidities and require a greater amount of care. To properly capture the risk score of complex patients through HCC coding, a

higher number of conditions must be accurately captured and recorded at the first encounter. If a comorbidity or other condition is overlooked, the risk of these complex patients would be undercoded and cannot be reflected in future adjustments. To address this issue CMS should alter its risk adjustment methodology to allow ACO risk scores to increase or decrease based on both newly assigned and continuously assigned beneficiaries to accurately reflect their complexity.

CMS should also applying changes to its Medicare Advantage risk adjustment methodology to the Medicare Shared Savings ACOs. Specifically, CMS announced in its Medicare Advantage 2017 Advance Notice and Draft Call letter that it plans to refine the risk adjustment model to improve the accuracy of payments to plans serving beneficiaries who are low income and dually eligible for Medicare and Medicaid. Applying a risk adjustment methodology that accounts for low income beneficiaries to ACOs would be particularly beneficial to Academic Medical Centers as they typically serve a higher number of low income patients with more complex conditions and should not risk being penalized for doing so.

Reopening Determinations of ACO Savings or Losses Should Be Limited to 2 Years

CMS proposes that if it determines that the amount of shared savings due to an ACO or the amount of shared losses owed by the ACO has been calculated in error, it may reopen the earlier payment determination and issue a revised initial determination and payment amount. If the reopening is for "good cause"," CMS proposes to limit its discretion to do so to a 4-year period after the date of notification to the ACO of the initial determination of shared savings or shared losses for the performance year. CMS provides a definition of "good cause" to include situations when there is an obvious error or when new and material evidence that was not available at the time of the payment determination results in a different conclusion. CMS states that "material" evidence would include the discovery of a technical error that affects the total net savings and losses for all ACOs in a performance year of 3 percent or more.

The AAMC is concerned that the 4 year time frame for looking back and recouping payments is excessive and burdensome. A standard ACO agreement period is for 3 years so a 4 year time frame would add additional burden as the ACO may not be in the program anymore. **We recommend that the period be shortened to 2 years.** ACOs should not be penalized for errors that CMS had made in the payment determination process. **CMS should consider holding ACO's harmless for technical errors made by CMS in the payment determination process. Finally, an individual ACO should have the ability to appeal a payment determination that may have been made in error.**

Facilitating Transition to Performance-Based Risk

CMS remains concerned about the small number of ACO's that have chosen to enter two-sided risk models. CMS proposes to add a participation option that would allow eligible Track 1 ACOs to defer by one year entrance into a performance-based risk model (Track 2 or 3) by extending their first agreement period under Track 1 for a fourth performance year. This includes ACOs that would be eligible to renew for their second agreement under Track 1 but are willing to move earlier to Track 2. CMS believes the additional year could allow such ACOs to further develop necessary infrastructure to meet the program's goals, such as further developing their care

management services, improving quality performances, and implementing electronic medical records.

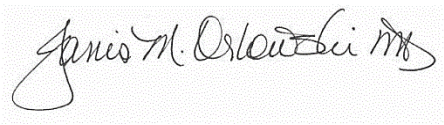
We believe that it is important to continue to allow the Track One option for ACOs in their first and second agreement period if they choose so that they can begin to understand alternative payment models and to gain experience with population health management. Nearly all of the Shared Savings Program ACOs led by academic medical centers participate in Track One, and many would have faced the unfortunate prospect of leaving the program if prematurely forced into taking downside risk. Although we are unsure of the level of interest in moving more rapidly to Track 2, we support the CMS proposal to allow an additional year to prepare for Track 2. Depending on how CMS defines eligible APMs under MACRA, there could be increased interest in moving more rapidly to accepting financial risk under Track 2.

Another change in policy that may encourage ACOs to take on two-sided risk models in the future would be to allow ACOs to split Tax Identification Numbers (TINs) so that a subset of their providers could take on greater risk. Organizations that use a single TIN to cover a vast array of providers may be reluctant to take on additional risk of the full patient population that would be attributed to their TIN. Therefore, the AAMC encourages CMS to allow ACOs to form on the basis of partial TINs. Doing so would allow large organizations, such as academic medical centers and their faculty practice plans, to enter the program with a subset of their providers (e.g. primary care) rather than staying away from two-sided risk until they feel more confident of success.

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**.**

Sincerely,



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