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Via Electronic Submission (www.regulations.gov)

April 19, 2017

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
ATTN: CMS-5519-IFC
7500 Security Blvd.
Baltimore, MD 21244-8013

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

Dear Ms. 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) interim final rule with comment period entitled, *Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model; Delay of Effective Date*, 42 CFR Parts 510 and 512. The AAMC is a not-for-profit association representing all 145 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, and 80 academic and scientific societies. Through these institutions and organizations, the AAMC represents 160,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

As a facilitator convener under the Bundled Payments for Care Improvement (BPCI) initiative, we have a deep interest in the promise of bundled payments to create the right incentives for the provision of high quality, efficient care. AAMC also supports providers implementing the Comprehensive Care for Joint Replacement (CJR) program and Oncology Care Model (OCM). Altogether, AAMC actively supports approximately 60 hospitals engaged in Medicare bundled payment programs. The lessons garnered from this experience heavily inform the content of this comment letter.

AAMC applauds CMS for creating new opportunities for providers to engage in alternative payment models, and for giving great consideration to designing a program that reflects the clinical and financial realities of these conditions. AAMC recommends that the EPM start date be pushed back to January 1, 2018, and that related program timelines be adjusted accordingly. Specifically, the AAMC strongly urges CMS to make the following changes:

- Delay the EPM start date from October 1, 2017 to January 1, 2018;

- Delay the onset of mandatory downside risk until 2020;
- Delay the onset of two thirds regional target pricing until 2020;
- Modify the effective date of changes to CJR from October 1, 2017 to July 1, 2017; and
- Maximize opportunities for providers to participate in an Advanced Alternative Payment Model (APM).

DELAY EPM MODEL START DATE UNTIL JANUARY 1, 2018

In the interim final rule, CMS delayed the EPM model start date until October 1, 2017, but proposed to consider an additional delay of the applicable date until January 1, 2018. The AAMC firmly recommends that the EPM start date be pushed back to January 1, 2018 in order to: 1) allow hospitals adequate time to prepare for the program, and 2) facilitate a more streamlined reconciliation process. Many hospitals in the 98 Acute Myocardial Infarction (AMI) and Coronary Artery Bypass Graft (CABG) Metropolitan Statistical Areas (MSAs) have limited experience operating under risk-based models. In order to appropriately direct the resources to thoughtfully implement a bundled payment program, hospital administrative and clinical staff must undertake many activities, including but not limited to the following:

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

The academic medical centers (AMCs) of the AAMC's BPCI Collaborative required 6 to 12 months to prepare for BPCI. Sites that are new to EPMs deserve the same timeline in order to assure success. However, hospitals in the CABG and AMI EPMs did not learn of their required participation in EPMs until the December 2016 release of the EPM Final Rule.

Furthermore, as with any change in administration, the future of rules that have yet to go into effect is uncertain. In fact, this interim final rule represents the second time the effective date of the EPM final rule has been postponed, with the first postponement occurring in February 2017. The ambiguity surrounding the future of EPMs has posed challenges to hospitals in their attempts to determine where and how to invest in implementation. The EPM start date must be delayed to provide hospitals with adequate preparation time and in so doing maximize the benefit of clinical transformation for patients.

A delay in the EPM start date will also facilitate a more streamlined reconciliation process. The AAMC concurs that maintaining at least a 6 month performance period is preferable for the first performance year. Given the length of the episodes, the October 1, 2017 model start date does not provide an adequate length for performance year one. Since episodes are attributed to the quarter in which they end, EPM episodes beginning on or after October 1, 2017 will be attributed to the first quarter of 2018, rather than the fourth quarter of 2017. Consequently, any EPM episodes occurring during 2017 will be included in the 2018 reconciliation. In order to maximize the duration of the first performance year, and enable a smoother reconciliation process, CMS should extend the EPM applicability date from October 1, 2017 to January 1, 2018 and align the first performance year with calendar year 2018. Therefore, the AAMC recommends that EPMs launch on January 1, 2018.

DELAY MANDATORY DOWNSIDE RISK UNTIL 2020

Under the EPM final rule, EPM participants will not face downside risk in 2018 unless the hospital voluntarily elects to assume downside risk beginning January 1, 2018 in order to qualify as an Advanced APM. Under the previous EPM start date of July 1, 2017, hospitals are afforded 2 performance years of no downside risk before they are subject to mandatory downside risk in January 2019. Clearly, this time frame is shortened under the revised program start date. While AAMC supports moving the start date to January 2018, under the current final rule hospitals will face financial risk after only one year of participation in the program. The AAMC recommends that providers are allowed at least 2 performance years of upside risk only.

Hospitals require multiple quarters of data in order to detect utilization trends and identify opportunities for intervention. However, there is a substantial time lag between when a service is rendered and when a provider receives the corresponding claim due to claims runoff. As a result, EPM hospitals are unlikely to gain actionable insights to improve financial performance within one year of participation. AAMC urges CMS to delay mandatory downside risk until 2020 in order to allow hospitals sufficient time to develop and implement strategies to improve clinical and financial performance.

DELAY REGIONAL TARGET PRICING TIMELINE

AAMC has concerns regarding the accelerated regional pricing timeline created as a result of the delay in the model start date. Under the current final rule, an EPM episode target price will be 100% based on regional data by 2020. However, the final rule also stipulated that hospitals would be measured against a target price that is predominantly based on their own historical performance (only one-third regional) for the first year and a half of EPMs (Figure 1).

Figure 1: EPM FINAL RULE: REGIONAL PRICING TIMELINE

	Performance Year 1 Jul. 1, 2017-Dec. 31, 2017	**Performance Year 2** Jan. 1, 2018-Dec. 31, 2018	**Performance Year 3** Jan. 1, 2019-Dec. 31, 2019	**Performance Year 4** Jan. 1, 2020-Dec. 31, 2020	**Performance Year 5** Jan. 1, 2021-Dec. 31, 2021
Regional component*	1/3	1/3	2/3	100%	100%
Hospital-specific component	2/3	2/3	1/3	0%	0%

*(U.S. Census region data)

The delay in the EPM model start date from July 1 to October 1 (and potentially January 1), *without a corresponding delay in the regional pricing timeline*, does not provide sufficient time for hospitals to adjust to majority regional pricing by implementing care interventions or streamlining their processes. Hospitals require ample time to review data prior to assuming increased risk under majority regional pricing. For example, SHFFT hospitals may prepare for regional pricing by comparing trends in post-discharge spending between their facility and regional hospitals, and modify their post-acute care strategy accordingly in order to mitigate potential losses or increase the likelihood of generating savings under a regional pricing model. However, strategies such as these require adequate time to devise and implement. Accordingly, AAMC recommends that CMS postpone the onset of two thirds regional target pricing until 2020 and 100% regional target pricing until 2021 (Figure 2).

Figure 2: AAMC RECOMMENDATION: REGIONAL PRICING TIMELINE

	Performance Year 1 Jan. 1, 2018-Dec. 31, 2018	**Performance Year 2** Jan. 1, 2019-Dec. 31, 2019	**Performance Year 3** Jan. 1, 2020- Dec. 31, 2020	**Performance Year 4** Jan. 1, 2021-Dec. 31, 2021
Regional component*	1/3	1/3	2/3	100%
Hospital-specific component	2/3	2/3	1/3	0%

*(U.S. Census region data)

MODIFY THE EFFECTIVE DATE OF CHANGES TO CJR FROM OCTOBER 1, 2017 TO JULY 1, 2017

In the EPM Interim Final Rule, CMS proposes to delay the effective date of the changes to CJR contained in the EPM Final Rule until October 1 (or potentially January 1) in order to align CJR with the EPMs. Although AAMC supports the CMS proposal to delay EPMs until January 1, 2018, the AAMC does not support the CMS proposal to concurrently delay changes to CJR as this would

bar CJR participant hospitals from implementing necessary improvements to the program regarding beneficiary notification and gainsharing for an additional 6 months.

In the EPM Final Rule, CMS modified the CJR beneficiary notification policy, offering hospitals increased flexibility when designing care interventions. Previously, CMS required all CJR collaborators to notify beneficiaries of their participation in the CJR program as soon as the patient first received services from the CJR collaborator, regardless of the urgency of the patient's condition. However, in the EPM Final Rule, CMS recognized that this requirement may not be feasible in emergencies and may inadvertently create additional confusion and distress for patients experiencing a traumatic event. As a result, CMS revised the CJR beneficiary notification policy to permit CJR collaborators to delay beneficiary notification until discharge in fracture cases, effective for episodes beginning on or after July 1, 2017. The AAMC supports CMS's December 2016 decision to delay beneficiary notification in CJR fracture cases, since the policy enables hospitals to prioritize clinical care, rather than administrative policy, at the moment of the patient's greatest need. If, however, CMS delays the effective date of changes to CJR contained in the EPM Final Rule until October 1 (or potentially January 1), CJR hospitals will be unable to implement this provision for an additional 3-6 months. AAMC urges CMS to amend the effective date of changes to CJR from October 1, 2017 to July 1, 2017 in order to reduce: 1) provider burden, and 2) beneficiary/family confusion and/or distress.

The EPM Final Rule significantly improved CJR hospitals' flexibility in gainsharing by adding additional entities with which hospitals may share financial risk and reward. CMS's inclusion of non-physician practitioner group practices, therapy group practices, therapists in private practice, and comprehensive outpatient rehabilitation facilities, as collaborators beginning July 1, 2017, enables hospitals to engage crucial care partners through the use of financial incentives. The AAMC supports CMS's original decision to include these entities as collaborators beginning July 1, 2017 and urges CMS to move the effective date of changes to CJR forward from October 1 to July 1, 2017 in order to allow hospitals to begin engaging these care partners through gainsharing.

MAXIMIZE INCLUSION IN ADVANCED ALTERNATIVE PAYMENT MODELS

The AAMC commends CMS for the decision to include the EPMs and CJR Track 1 as Advanced APMs and appreciates CMS' indication to include BPCI 2.0 as an Advanced APM in 2018**.** However, the AAMC has concerns that a further delay past January 1, 2018 may jeopardize hospitals' ability to qualify as Advanced APMs in 2018. Because CMS determines which alternative payment models qualify as Advanced APMs for the 2018 calendar year on January 1, 2018, any delay past this date may prevent EPM and CJR Track 1 hospitals from obtaining Advanced APM status for 2018. Consequently, the AAMC reiterates that the EPM Model start date be precisely January 1, 2018 in order to maximize inclusion in Advanced APMs.

EXCLUDE IME AND DSH FROM EPM TARGET PRICES

Inclusion of the indirect medical education adjustment (IME), disproportionate share hospital (DSH) payments, and other add-on payments in EPM baseline data and target prices may inadvertently create perverse incentives for post-acute care providers and physician group practices to refer patients away from AMCs. Thus, AAMC strongly supports CMS's proposal to

exclude special Medicare payment provisions, such as IME, DSH payments, and other add-on payments, from EPM target price and performance period spending calculations.

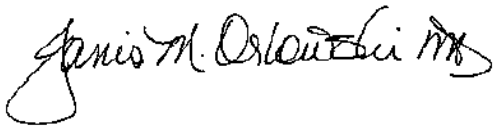
SUPPORT FOR HOSPITALS AS EPISODE INITIATORS

In our experience, Episode Initiators who assume the majority of the risk of the episodes in which they participate are maximally invested in care transformation and the program overall. Throughout the course of BPCI, AAMC has observed that hospitals, as opposed to other Episode Initiators, 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. Thus, the AAMC supports CMS's decision to establish hospitals as Episode Initiators in the EPMs.

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.

Sincerely,



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