Association of
American Medical Colleges
655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399
T 202 828 0400
www.aamc.org

Via Electronic Submission (www.regulations.gov)

October 12, 2017

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
ATTN: CMS-5524-P
7500 Security Blvd.
Baltimore, MD 21244-8013

Re: Medicare Program; Cancellation of Advancing Care Coordination through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model, File Code CMS-5524-P

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) proposed rule entitled, *Medicare Program; Cancellation of Advancing Care Coordination through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to Comprehensive Care for Joint Replacement Payment Model*, 82 *Fed.Reg* 39310 (August 17, 2017). The AAMC is a not-for-profit association representing all 147 accredited U.S. medical schools; nearly 400 major teaching hospitals and health systems, and 80 academic and scientific societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 167,000 full-time faculty members, 88,000 medical students, and 124,000 resident physicians.

As a facilitator convener under the Bundled Payments for Care Improvement (BPCI) initiative, the AAMC has a deep interest in the promise of bundled payments to create the right incentives for the provision of high quality, efficient, and lower cost care. AAMC also provides support for providers implementing the Comprehensive Care for Joint Replacement (CJR) program and Oncology Care Model (OCM). Altogether, AAMC actively supports approximately 69 academic hospitals and health systems engaged in the learning needed to transform clinical care in the Medicare bundled payment programs. The lessons garnered from this experience heavily inform the content of this comment letter.

AAMC commends CMS for its commitment to creating new opportunities for providers to engage in alternative payment models (APMs), and for giving careful consideration to designing programs which reflect the clinical and financial realities hospitals face. AAMC believes that the proposal to cancel the Episode Payment Models (EPMs) and instead provide opportunities for voluntary participation in the next iteration of BPCI reflects an understanding that providers require more certainty and advance notice in order to successfully prepare for and implement APMs. With that lesson in mind, AAMC urges CMS to establish more certainty for the provider community regarding the future path to value-based care. Currently, CJR hospital participants in the proposed voluntary MSAs lack the necessary information to make a decision regarding participation, as well as adequate incentives to remain in the program. Specifically, the AAMC strongly urges CMS to make the following changes:

- Create an additional opt-in period in January 2019 to allow hospitals greater flexibility in participation;
- Reduce the regional component of the CJR target price in Performance Years 3 through 5;
- Reexamine diagnoses which could qualify for exemption from CJR; and
- Release programmatic details regarding the next iteration of BPCI 2.0 by November 1, 2017.

EPISODE PAYMENT MODELS

CMS Must Eliminate the Uncertainty Surrounding the Future of APMs

The EPMs were initially scheduled to launch July 1, 2017, but were subsequently delayed to an October 1, 2017, and then January 1, 2018 start date. In this rule, CMS proposes to cancel the EPMs, citing stakeholder concerns with the design of the models and the Agency's preference for voluntary initiatives. Although the AAMC appreciates CMS' recognition that hospitals are in differing stages of readiness to launch alternative payment models, the Association urges CMS to take a more consistent approach in the future, as the uncertainty caused by these many announcements followed by delays has hampered providers' financial and strategic planning. This rule represents the third time CMS has either postponed the effective date of EPMs or proposed a significant modification to the model. The ambiguity surrounding the future of EPMs has posed challenges for hospitals in their attempts to determine where and how to invest in implementation.

Many AAMC member hospitals invested significant resources (both monetary and nonmonetary) to prepare for the program's launch. In order to appropriately direct the resources to thoughtfully implement the EPMs, AAMC hospitals have undertaken the following activities:

- Educated staff and physicians on EPM program rules and policies;
- Developed clinical protocols for post-acute care;
- Built internal quality and cost monitoring tools;
- Budgeted for and hired new staff, including program managers and care coordinators;

- Analyzed Medicare claims data to identify risks and opportunities to expertly target customized care interventions;
- Established multidisciplinary teams;
- Met regularly to discuss work plans and next steps;
- Updated patient education materials and processes; and
- Redesigned clinics to a care coordination model.

These activities have allowed hospitals to experiment in quality and care delivery model changes which improve the continuum of care. Given the extensive preparation many hospitals have conducted in anticipation of the program's launch, CMS' assumption that the proposed cancellation will not have any cost to providers is incorrect. AAMC urges CMS to swiftly establish the next iteration of BPCI, which would contain opportunities to participate in similar episodes that would have existed under EPMs. Furthermore, AAMC strongly recommends that CMS cease the practice of announcing and then repeatedly delaying models, as well as other actions that perpetuate uncertainty regarding the future of Medicare reimbursement and delivery models.

Release of BPCI 2.0/BPCI ADVANCED Program Details

In the rule, CMS indicates that providers may still have an opportunity to participate in an Advanced APM during Calendar Year (CY) 2018. CMS notes, "Building on the BPCI Initiative, the Innovation Center expects to develop new voluntary bundled payment models during CY 2018 that would be designed to meet the criteria to be an Advanced APM".[1] The AAMC appreciates CMS' expressed intent to design a new voluntary bundled payment model during 2018 and encourages the Agency to engage stakeholders in this process to encourage optimal program design. The Association urges CMS to release programmatic details as soon as possible in order to 1) maintain the momentum towards value-based payment reform, 2) aid hospitals' decisions regarding participation in CJR, and 3) provide more opportunities for providers to participate in Advanced APMs. Important programmatic details regarding the future iteration of BPCI include the following**:**

- Program timelines, including application periods and start and end dates;
- Target price methodology;
- Episode specifications;
- Precedence and model overlap rules; and
- Processes for accessing baseline and performance period claims data.

The AAMC encourages CMS to maximize physician inclusion in Advanced APMs. In order to allow clinicians who would have been included in Track 1 of the AMI, CABG or SHFFT models an opportunity to achieve Qualifying APM Participant (QP) status under the Advanced APM

[1] Medicare Program; Cancellation of Advancing Care Coordination through Episode Payment and Cardiac Rehabilitation Incentive Payment Models; Changes to the Comprehensive Care for Joint Replacement Payment Model, 82 FR 39310.

track in the Quality Payment Program in 2018, CMS should design BPCI 2.0 to qualify as an Advanced APM for 2018.

COMPREHENSIVE CARE FOR JOINT REPLACEMENT MODEL

CMS proposes to reduce the number of metropolitan statistical areas, or MSAs, required to participate in CJR from 67 to 34, and to permit hospitals in the remaining 33 voluntary MSAs to choose whether to continue to participate in the model. Additionally, CMS would exempt rural hospitals and low-volume hospitals from mandatory participation.

To allow hospitals eligible for voluntary participation to continue in the model, CMS proposes a one-time voluntary participation election period, beginning January 1, 2018, and ending January 31, 2018. During this time, hospitals which elect to continue in the CJR model can submit a participation election letter to CMS. A hospital's decision is effective February 1, 2018.

CMS Must Provide More Opportunities to Opt-In to the Model

While the AAMC understands that CMS proposed a one-time voluntary election period to reduce confusion as to who is participating in Performance Years 3-5, CMS' proposal discourages hospitals from continued preparation for and participation in CJR. Because hospitals that opt-in cannot exit the model in future years, hospitals hesitant to join for the remainder of the model will likely decide to drop out of CJR.

In order to continue the transition towards value-based care and help ensure the continued success of the program, **AAMC urges CMS to not finalize the one-time voluntary election period, and instead create an additional opt-in period in January 2019.** A second opt-in period is necessary to maximize future participation in CJR, and to afford providers with certainty on future CMS policy impacting the CJR model. The AAMC's proposal would: 1) allow BPCI hospitals to enter CJR following the conclusion of BPCI in September 2018, and 2) provide CJR hospitals in the voluntary MSAs additional time to evaluate the impact of CMS' recent OPPS Proposed Rule on CJR (discussed below).

Information Needed Regarding CMS' CY 2018 OPPS Proposal to Remove Total Knee Arthroplasty from the Inpatient Only List

In the Calendar Year 2018 OPPS Proposed Rule, CMS proposed to remove total knee arthroplasty (TKA) from the Inpatient Only (IPO) list. If finalized, this policy would create significant negative financial implications for hospitals in CJR. As a result, in our comment letter, AAMC urged CMS not to finalize this proposal without first using notice and commenting to adopt an appropriate adjustment to major joint replacement episode target prices. The fate of TKA's position on the IPO list, as well as the potential corresponding target price adjustments, are crucial to hospitals' decisions regarding participation in CJR. It is highly unlikely that both of these issues will be resolved by January 2018. As a result, the AAMC strongly recommends that CMS create a second opt-in period in January 2019 to enable hospitals to make an informed decision regarding participation for Performance Years 4 and 5.

Information Needed Regarding Transitions between CJR, BPCI, and BPCI 2.0

In the rule, CMS did not address the options available to hospitals located in CJR MSAs that are also currently participating in BPCI. Under present CJR rules, if a hospital is participating in a lower extremity joint replacement (LEJR) episode under BPCI the hospital is exempt from CJR. However, if the hospital drops participation in BPCI LEJR, the hospital would immediately become a CJR participant. Other BPCI LEJR participant hospitals located in CJR MSAs would enter CJR once BPCI ends in September 2018.

The AAMC believes that the final rule must address the following scenarios:

1) Treatment of BPCI LEJR participant hospitals in CJR **mandatory** MSAs following the decision to drop BPCI LEJR or the conclusion of BPCI; and
2) Treatment of BPCI LEJR participant hospitals in the proposed **voluntary** MSAs following the decision to drop BPCI LEJR or the conclusion of BPCI.

Because a hospital's performance in BPCI is measured only against its own historical performance and not against its peers, requiring BPCI hospitals to enter CJR in the fourth performance year would expose hospitals to undue financial risk. By 2019, CJR target prices will be 100% regionally based. Consequently, if BPCI hospitals are required to participate in CJR beginning in 2019, these hospitals would be forced to abruptly transition from being measured against a 100% hospital-specific target price to a 100% regional target price. Therefore, the Association urges CMS to exempt BPCI hospitals in the proposed mandatory MSAs from compulsory participation after BPCI ends.

Additionally, CMS did not address whether hospitals currently at risk for BPCI MJR episodes in the proposed voluntary MSAs will be permitted to opt-in to CJR after BPCI concludes in the fall of 2018. Despite the financial risk involved in the transition between models, the AAMC recognizes that some BPCI hospitals may wish to voluntarily participate in CJR. Thus, the AAMC reiterates that CMS should create an additional opt-in period during January 2019 to allow BPCI hospitals in *both the mandatory and voluntary MSAs* the opportunity to participate in CJR.

Support for Creation of a Clinician Engagement List for CJR Track 1

AAMC applauds CMS for proposing to create the Clinician Engagement List for CJR Track 1 to allow clinicians not gainsharing with a hospital in CJR Track 1 to achieve QP status. The Association supports CMS' proposal to collect the Clinician Engagement List and Clinician Financial Arrangement List concurrently in order to minimize reporting burden on hospitals.

Recommended Programmatic Changes to CJR to Incentivize Participation

In the proposed rule, CMS asks stakeholders to provide recommended programmatic changes to incentivize eligible hospitals to remain in the CJR model voluntarily. The AAMC commends CMS for its willingness to improve the model and recommends that the Agency:

- Reduce the regional component of the target price in Performance Years 3-5, and
- Reexamine procedures and diagnoses which could qualify for exclusion from the model.

Reduce the Regional Component of the Target Price in PYs 3-5

CJR target prices are created using a blend of hospital-specific and U.S. Census region historical data. As the model progresses, the regional component of the target price increases from one-third in Performance Years 1 and 2 to two-thirds in Performance Year 3. Target prices will be 100% regional in Performance Years 4 and 5, as shown in Figure 1 below.

Figure 1: CJR Regional Pricing Timeline

	Performance Year* 1 Apr. 1, 2016-Sep. 30, 2016	**Performance Year 2** Oct. 1, 2016-Sep. 30, 2017	**Performance Year 3** Oct. 1, 2017-Sep. 30, 2018	**Performance Year 4** Oct. 1, 2018-Sep. 30, 2019	**Performance Year 5** Oct. 1, 2019-Sep. 30, 2020***
Regional component**	1/3	1/3	2/3	100%	100%
Hospital-specific component	2/3	2/3	1/3	0%	0%

*Because episodes are attributed to the year in which they end, episodes initiating on or after October 1 of a given year will be attributed to the next performance year.
**U.S. Census region data.
***Episodes beginning on or after October 1, 2020 will not be included in PY 5 reconciliation.

To determine the regional component of the target price, CMS calculates the average wage-adjusted LEJR episode payments for each of the nine census regions. Due to the vast size of the regions, substantial differences in care patterns and payments exist within each region. As a result, some providers are extremely disadvantaged while others are tremendously advantaged by the regional component of the target prices. For example, an academic medical center (AMC) hospital in New York City faces the same regional target price component as a community hospital in Elk County, Pennsylvania. Because care is less expensive in areas such as Elk County, the Elk County hospital will appear more efficient than the AMC hospital in New York City, making it easier for the community hospital to generate savings. Conversely, the urban AMC is more likely to sustain losses in CJR. Although the AAMC understands that regional pricing is necessary to drive national quality improvement and cost reduction, the Association has concerns regarding the dramatically rapid transition to regional pricing that is based on cost of living differences and not all attributable to cost of care differences. Therefore, AAMC recommends that CMS reduce the regional component of the target price in PY 3 to one-half, and increase to two-thirds in PYs 4-5, as shown in Figure 2.

Figure 2: AAMC Recommendation: Regional Pricing Timeline

	Performance Year 3 Oct. 1, 2017-Sep. 30, 2018	**Performance Year 4** Oct. 1, 2018-Sep. 30, 2019	**Performance Year 5** Oct. 1, 2019-Sep. 30, 2020***
Regional component**	1/2	2/3	2/3
Hospital-specific component	1/2	1/3	1/3

**U.S. Census region data.

In Performance Year 3, hospital performance will be compared not only against a target price predominantly based on regional data, but also against rebased historical Medicare claims data from 2014-2016. The steadily declining 470 trend factor calculated under BPCI indicates that across the nation Medicare payments for LEJR episodes are decreasing, meaning that rebased targets will likely be lower than the target generated from the original CJR baseline period (2012 – 2014). The fact that the rebasing and regional pricing increases are occurring simultaneously underscores the importance of the AAMC's regional pricing recommendation. The AAMC's proposed modification to the target price methodology will likely incentivize hospitals eligible for voluntary participation to remain in the model, since this will mitigate future financial risk.

CMS Should Re-Examine the Episode Exclusions List

Under current program rules, CMS utilizes the Episode Exclusions List to identify services that are excluded from CJR episodes. Excluded services do not factor into the reconciliation calculations that determine financial performance. However, as technology has progressed and new treatments are available for previously untreatable conditions, CMS' current Exclusion List may be out of date. In addition, as practices gain experience in bundled payment models, they are better able to identify patients with specific diagnoses who cannot be appropriately managed under a joint replacement episode. For example, many providers believe that cancer patients should be excluded from CJR.

Analysis of Medicare claims data from an AAMC's member's CJR patients show that the average CJR episode cost for the institution's cancer patients (including cancer as a primary or secondary diagnosis) was $8,280 higher than the average episode cost for non-cancer patients ($31,474 and $23,194, respectively). Notably, the higher average episode cost for cancer patients was driven primarily by higher average inpatient spending for cancer patients ($20,393) versus non-cancer patients ($13,036). The AAMC asks that CMS explore the relationship between cancer and CJR episode costs to determine whether an exclusion of cancer patients from the model is appropriate.

The AAMC recommends that CMS revisit the Exclusions List and evaluate whether additional exemptions are warranted through an annual rulemaking process. As CMS considers further programmatic changes to improve the model, the Agency should re-examine diagnoses which could qualify for exemption from CJR episodes.

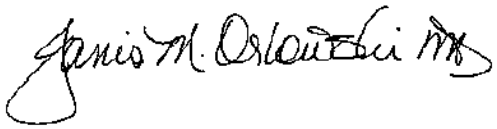
Support for Continued Exclusion of IME and DSH from CJR Target Prices

Inclusion of the indirect medical education adjustment (IME), disproportionate share hospital (DSH) payments, and other add-on payments in CJR baseline data and target prices may inadvertently create perverse incentives for post-acute care providers and physician group practices to refer patients away from teaching hospitals, even if those are the best institutions to care for patients. Thus, AAMC strongly supports CMS's current policy excluding special Medicare payment provisions, such as IME, DSH payments, and other add-on payments, from CJR target price and performance period spending calculations. Therefore, the Agency should continue this policy.

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,



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

cc: Jessica Walradt, AAMC