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

February 20, 2018

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-1702-IFC) Medicare Program; Medicare Shared Savings Program; Extreme and Uncontrollable Circumstances Policies for Performance Year 2017*

Dear Administrator Verma:

The Association of American Medical Colleges (AAMC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS' or the Agency's) interim final rule entitled *Medicare Program; Medicare Shared Savings Program; Extreme and Uncontrollable Circumstances Policies for Performance Year 2017* as published in the Federal Register December 26, 2017. The AAMC is a not-for-profit association representing all 149 accredited U.S. and 17 accredited Canadian medical schools; over 400 major teaching hospitals and health systems, and more than 80 academic and professional societies. Through these institutions and organizations, the AAMC represents 167,000 faculty members, 88,000 medical students, and 124,000 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 this interim final rule, CMS establishes extreme and uncontrollable circumstances policies for the Shared Savings Program that will apply to ACOs impacted by extreme and uncontrollable

events, such as Hurricanes Harvey, Irma, and Maria, and the California wildfires, effective for performance year 2017. These catastrophic events that are outside of the ACO's control likely result in increased utilization of medical services, higher rates of hospital admissions and longer stays, challenges associated with coordination of care for patients that have left the impacted areas, and many other related issues. As a result, the ACO could be unfairly assessed for the performance year based on the quality measures and could be held accountable for financial costs due to increased utilization of services resulting from the disaster.

AAMC strongly supports CMS' extreme and uncontrollable circumstances policy and recognition that new policies are warranted for addressing quality and financial performance of Shared Savings Program ACOs in affected areas. While this is an interim final rule for 2017, we are pleased that CMS invites public comments on policies that should be considered when developing proposals that would be more permanent to address extreme and uncontrollable circumstances that occur in future performance years.

**Determination of Quality Performance Scores for ACOs in Affected Areas**

For purposes of determining quality performance scoring for year 2017, CMS will set the ACO's minimum quality score to equal the mean Shared Savings Program ACO quality score for all ACOs for performance year 2017 if 20 percent or more of an ACO's assigned beneficiaries reside in an area impacted by the disaster or the ACO's legal entity is located in such area. CMS states that in the event an affected ACO is able to complete quality reporting for performance year 2017, and the ACO's calculated quality score is higher than the mean Shared Savings Program ACO quality score, CMS would apply the higher score. In addition, CMS states that if the ACO receives a quality score based on the mean quality score, the ACO is not eligible for bonus points awarded based on quality improvement because CMS is unable to assess the ACO's improvement on established quality measures.

AAMC supports CMS' policy to allow the ACO to use the higher of the ACO's calculated quality score in the event the ACO completes reporting or the mean Shared Savings Program ACO quality score. We believe it is important to ensure that ACOs in these disaster areas have the option of selecting whether or not to complete quality reporting. However, we are concerned that there is no way for ACOs that receive the mean Shared Savings Score to demonstrate quality improvement and receive bonus points. We recommend that CMS consider alternative mechanisms by which these ACOs could demonstrate quality improvement as they should not be penalized.

In the interim final rule, CMS states that with regard to MIPS APM scoring standard, the MIPS eligible clinicians in ACOs that do not completely report quality for 2017 and therefore receive the mean quality score would receive a score of zero percent in the MIPS quality performance category. CMS states that because these eligible clinicians would receive a 100 percent score in the improvement activities category, they would be above the performance threshold and therefore avoid a negative payment adjustment in 2019. While the impact may not be significant in payment year 2019 due to the low performance thresholds under MIPS for that year, we recommend that CMS establish a policy in the future that would not penalize these ACOs by giving them a zero score under the MIPS quality category. CMS should consider other

alternatives, such as redistributing weights in performance categories under the MIPS program as opposed to providing a zero score for quality. In the Quality Payment Program rule CMS has set forth policies that would allow redistribution of weights for the performance category when warranted. Without such a policy, there will be no opportunity for positive adjustments and eligible clinicians participating in these ACOs could be penalized with lower payment amounts.

**Mitigating Shared Losses for ACOs Participating in a Performance Based Risk Track**

CMS modifies the payment methodology under Tracks 2 and 3 to mitigate shared losses owed by ACOs affected by extreme and uncontrollable circumstances during performance year 2017. Specifically, CMS will reduce the ACO's shared losses if any, by an amount determined by multiplying the shared losses by two factors: 1) the percentage of the total months in the performance year affected by an extreme and uncontrollable circumstance; and 2) the percentage of the ACO's assigned beneficiaries who reside in an area affected by an extreme and uncontrollable circumstance.

We commend CMS on its policy of mitigating shared losses owed by the impacted Track 2 and Track 3 ACOs. However, we urge CMS to also address the financial impact of these extreme and uncontrollable circumstances on Track 1 ACOs. While Track 1 ACOs do not share performance-based risk for losses, they have invested significant resources to participate in the program, such as the financial investments associated with the implementation and infrastructure support of ACOs. For example, CMS has estimated that the first year costs are approximately $1.8 million. These ACOs will be exposed to the risk that these significant costs will never be recouped as the ACO's ability to realize savings may be put in jeopardy by these disasters. We recommend that CMS establish a policy that will take this into consideration in calculating not only shared losses for Tracks 2 and 3 but also shared savings for all tracks.

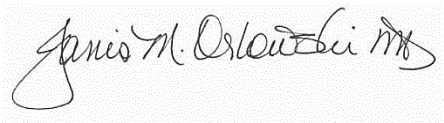
CMS includes a discussion in the rule regarding the potential impact that the additional costs incurred as a result of an extreme or uncontrollable circumstance would have on the benchmark for the ACO's subsequent agreements. CMS plans to make no changes at this time but will observe the impact of the 2017 hurricanes and wildfires on ACO expenditures and revisit the need to adjust benchmarks. We recommend that CMS monitor the impact of this policy and consider actuarial methods to apply trend adjustments to the baseline to account for the extreme and uncontrollable circumstances. Creating the right benchmarks for ACOs is a key to success for ACO participants and is essential for keeping those participants in the program. It is important to ensure that the benchmark methodology does not adversely impact ACOs in the impacted areas. CMS should identify ways to mitigate any negative impact on ACOs.

**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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Chief Health Care Officer

cc: Gayle Lee, AAMC
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