MEDPAC Medicare Payment Advisory Commission

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Mr. Andrew Slavitt, Acting Administrator
Department of Health and Human Services
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

RE: File code CMS-1644-P

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) **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.** The proposed rule addresses several innovations in rebasing and updating benchmarks for Medicare shared savings program (MSSP) accountable care organizations (ACOs). In view of their competing demands and limited resources, we especially appreciate your staff's thoughtful approach to improving the MSSP.

In this letter we comment on several issues raised in the proposed rule with an emphasis on your proposals for rebasing and updating ACO benchmarks. We find that your proposals represent a balanced approach to addressing several issues MedPAC and others have raised in the past about rebasing benchmarks for ACOs including:

- taking into account regional fee-for-service (FFS) spending as well as historical ACO spending when rebasing benchmarks,
- including ACO beneficiaries in the calculation of regional FFS spending, and
- including only comparable FFS beneficiaries (i.e., only those who would be eligible for ACO assignment) when determining regional FFS spending.

We also comment on several issues related to risk adjustment and updating benchmarks for ACOs. Your proposals on all of these issues represent an important step forward for the MSSP.

Accounting for regional FFS spending in ACO benchmarks
As we discussed in our February 2, 2015 comment letter on the December 2014 MSSP proposed rule, it is important to take into account the difference between an ACO's historical benchmark

and regional FFS spending to increase program equity.[1] Under the current benchmarking methodology, an ACO's benchmark is rebased at the beginning of each new three-year agreement period. In a situation in which a more efficient ACO and a less efficient ACO are both operating in the same market, in the second and subsequent agreement periods, the more efficient ACO will have a progressively lower benchmark and reduced opportunity for shared savings compared to the less efficient ACO. This does not seem equitable and could cause the more efficient ACO to leave the ACO program.

To remedy this undesirable outcome CMS proposes to incorporate a regional FFS component into the calculation of the rebased benchmarks. CMS proposes to calculate the difference between regional FFS spending and the historically-based benchmarks and add 35 percent of the difference to the historical spending (increasing to 70 percent for subsequent agreement periods). Thus, if an ACO's benchmark based on historical spending were lower than the regional spending, the blended benchmark would represent an increase to the historically-based benchmark (and conversely, if historical spending were higher, a decrease). Therefore, the approach will drive rebased ACO benchmarks toward regional FFS spending in the market and make benchmarks for ACOs in the market more equitable.

We endorse this approach to the problem, particularly when coupled with an examination of results before switching to the higher weight for the regional spending component.

It is important to move deliberately and monitor results because there could be a tendency for only ACOs with historically-based benchmarks below regional FFS spending to remain in the program and for higher-spending ACOs to exit (because it could be difficult for them to meet their rebased benchmarks). This could result in less program savings from the MSSP for two reasons. First, if higher-spending ACOs were to exit, then program savings from higher-spending ACOs reducing their spending growth would disappear. Second, the remaining lower-spending ACOs could keep spending below the new blended benchmark by continuing to do what they had been doing rather than by increasing their efforts to reduce spending growth. This could further diminish program savings. These concerns would be somewhat ameliorated by including beneficiaries attributed to ACOs in the regional FFS spending calculation as discussed below, but results should be actively monitored—particularly before moving to the higher (70 percent) adjustment. Therefore, we support CMS's proposal to examine results before switching to a higher weight.

Blending regional FFS spending into ACO benchmarks raises additional issues that are discussed in the proposed rule. We comment on three of these below.

Including only "assignable" beneficiaries in regional FFS spending calculations

As discussed in the proposed rule, it is important to include only those FFS beneficiaries who could be assigned to ACOs in calculations of regional FFS spending. This is because the level of spending for beneficiaries who can be assigned to ACOs differs from the level of spending for

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[1] MedPAC. Comment letter to CMS on Medicare shared savings program accountable care organizations proposed rule (CMS-1461-P). February 2, 2015. http://www.medpac.gov/documents/comment-letters/medpac-comment-on-cms-s-medicare-shared-savings-program-accountable-care-organizations-proposed-rule.pdf?sfvrsn=0

beneficiaries who do not meet all of the requirements to be assigned to ACOs. In particular, the requirement that a beneficiary has had a qualifying visit with a primary care physician in the past twelve months greatly effects the spending level (and spending growth) compared to beneficiaries without such a visit. Including beneficiaries without such primary care visits in the FFS regional spending amount would incorrectly lower the FFS spending level used as the regional component of the rebased ACO benchmarks. (It would also result in a higher than warranted rate of growth from year to year because the first year spending would be low.) The appropriate point of comparison for the historically-based ACO benchmarks (which by definition only include spending for attributable beneficiaries) is spending for assignable FFS beneficiaries in the region. Thus, we support the proposal to include only assignable FFS beneficiaries in the regional spending calculations.

Including beneficiaries attributed to ACOs in regional FFS spending calculations
A second issue is whether or not to include beneficiaries attributed to ACOs in the calculation of regional FFS spending. We support CMS's proposal to include the beneficiaries assigned to ACOs in that calculation. As we have suggested in the past, including those beneficiaries will result in more stable regional FFS spending calculations because there will be a greater number of beneficiaries in each county included in the calculation than if attributed beneficiaries were not included. In addition, if ACOs are successful, the inclusion of their beneficiaries in FFS county spending will serve to control the growth in calculated regional FFS spending. As regional FFS spending is incorporated into ACO benchmarks, this will allow the Medicare program to capture further savings as ACOs' benchmarks move toward the regional average, as discussed above.

Another approach to increase stability in the regional FFS spending calculations would be to increase the number of years of data included in the calculation. In counties with a small FFS population, one year of data (as is proposed) may not result in a stable estimate of spending because of random variation in Medicare spending from year to year. The Medicare Advantage (MA) program has addressed this issue by using a five-year rolling average for county-level spending estimates. Further, for MA, CMS calculates county spending relative to the national average each year, and averages the relative numbers, which makes it unnecessary to trend dollars forward to current year values. In cases in which the MA program has crafted solutions to similar problems it might be helpful for CMS to use a similar approach in the MSSP. This could also further the eventual goal of the Commission to bring about synchronization among FFS, MA, and ACOs so that the programs could be compared more equitably.

Risk adjustment
A final issue in incorporating regional spending into ACO benchmarks is risk adjustment. To blend regional FFS spending and historically-based benchmarks, the per capita spending for each must be for beneficiaries with similar risk. This requires that spending be risk-adjusted. CMS proposes to risk-adjust spending using the CMS-hierarchical condition category (CMS-HCC) risk score. We support this approach to risk adjustment and agree that CMS will need to monitor risk scores for beneficiaries attributed to ACOs to see if there is any tendency toward more intensive coding for those beneficiaries than for beneficiaries not attributed to ACOs. Differences in coding practices between ACO clinicians and other FFS clinicians will need to be taken into account when blending

regional FFS spending into ACO benchmarks to ensure equity. Similar efforts are being made in regard to MA and FFS.

Updating benchmarks
In the proposed rule, ACO benchmarks for the second and subsequent agreement periods would be updated by the regional rate of growth in spending rather than by national growth as is now the case. One reason for this proposed change is to be able to account for changes in factors outside the ACO's control that affect regional spending, such as changes to the region's hospital wage index. This is a reasonable concern, and the lack of such an adjustment has been cited by certain ACOs in their decisions to leave the ACO program. However, it might be preferable to retain the national growth amount and directly adjust for such changes (e.g., the hospital wage index) rather than move to a regional growth rate. This is because, if ACOs become dominant in a region and are successful, they would limit the rate of spending growth per capita in the region. Hence, their incentive to control spending growth would be limited if the update for the benchmark would be reduced by their success in reducing spending growth. Therefore, we do not support the move to a regional amount when computing updates and instead would suggest that CMS investigate adjusting spending for area wage index changes directly. Spending is already being adjusted to remove IME, DSH, and uncompensated care spending, so this should not be a new burden. In combination with the proposal for risk adjustment, it would, in effect, move the trend measure more to one of utilization than raw spending, which we have suggested in previous letters would be superior.

Conclusion
The Commission appreciates the opportunity to comment on the proposed rule and is encouraged by the direction CMS is taking. We also value the ongoing cooperation and collaboration between CMS and Commission staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of these comments, please feel free to contact Mark Miller, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Francis J. Crosson, M.D.
Chairman