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February 2, 2015

Ms. Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
200 Independence Avenue, SW  
Suite 314-G  
Washington, DC 20201

**RE: File code CMS-1461-P**

Dear Ms. Tavenner:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) *Medicare shared savings program: Accountable care organizations proposed rule*, published in the Federal Register on December 8, 2014. The proposed rule addresses the next phase of the Medicare Shared Savings Program (MSSP). 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 discussed in the proposed rule, some of which we raised in our June 16, 2014 letter.<sup>1</sup> We appreciate your staff taking up the issues that MedPAC and others have raised and their thoughtful analysis of each of these issues. In some cases the rule proposes specific approaches (such as creation of a new Track 3) and in others asks for comments after discussing several approaches without proposing any single approach (such as benchmarking). We think this speaks to the complexity of these issues and hope our comments will help CMS think through which approaches might best serve Medicare and its beneficiaries.

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<sup>1</sup> MedPAC. *Comment letter to CMS on accountable care organizations*. June 16, 2014. [http://medpac.gov/documents/comment-letters/comment-letter-to-cms-on-accountable-care-organizations-\(june-16-2014\).pdf?sfvrsn=0](http://medpac.gov/documents/comment-letters/comment-letter-to-cms-on-accountable-care-organizations-(june-16-2014).pdf?sfvrsn=0)

Taken together, several of the issues discussed—the new Track 3 for ACOs, regulatory relief, and benchmarking to the local market—could define the future of the MSSP. A “new” MSSP could incorporate two sided risk, use prospective assignment, allow for beneficiaries to share in savings (e.g., through lower cost sharing), have sufficient regulatory relief for providers to engage in care coordination, provide an opportunity for partial capitation, and follow a new approach to benchmarking that promotes essential equity and efficiency that will be vital to the success of the program. This “new” MSSP would have stronger incentives for efficiency, better means to achieve it, and create more of an impetus for providers—even higher-cost providers—to want to form or join efficient ACOs.

However, like any voluntary program in Medicare, providers could decide not to participate in the MSSP and simply continue in traditional fee-for-service (FFS). One approach for encouraging providers to move from traditional FFS to ACOs would be to weaken ACO performance standards and accountability. We do not endorse this approach. The goal of the MSSP should be to create the conditions that will reward efficient ACOs that can create real value for the Medicare program, its beneficiaries, and the taxpayers—not to maximize the number of ACOs or to ensure that every provider can join an ACO. An alternative approach that some have suggested would encourage providers away from traditional FFS by lowering FFS payment rates below ACO providers’ payment rates. However, such an approach complicates the creation of equitable benchmarks across payment models, and has the potential to reward ACO providers simply for being in an ACO irrespective of their actual performance.

A strategy to encourage movement from traditional FFS that is more consistent with the goals of the “new” MSSP we discuss here would reward ACO providers both with shared savings from reduced utilization, and with quality bonus payments when their quality of care exceeds FFS in the relevant market. The first method of reward is that contemplated by the ACO concept—and below we offer comments that would give ACOs more tools to make those shared savings more achievable. The second is to reward providers organized into ACOs that can achieve *population* health outcomes that are better than those produced by traditional FFS in their market. This is being done in some manner in the MA program now; a redesigned approach could apply to both MA plans and ACOs. To be clear, providers who are not in an entity such as an ACO or MA plan that can take responsibility for a population of Medicare beneficiaries would not be eligible to

receive such a bonus. The availability of a population quality bonus could make the “new” MSSP program more attractive to providers relative to traditional FFS without differentiating base payment rates between providers in traditional FFS and those in ACOs, and without weakening performance standards or accountability. Beneficiaries may also migrate to MSSP providers because of lower cost sharing and higher quality—which would further encourage providers to join an MSSP ACO.

An improved MSSP—incorporating the new Track 3, more equitable benchmarks, and a new approach to rewarding value—is a long-range vision that will require considerable effort to design. However, it will better meet the goals of the Medicare program and more equitably reward providers who join the program and create real value. We look forward to assisting CMS in future rulemaking to help attain that vision.

In the body of this letter, we offer specific comments on three issues raised in the proposed rule:

- creating a new Track 3 for ACOs in the MSSP that would incorporate prospective attribution of beneficiaries to ACOs and two-sided risk (shared savings and shared losses),
- waiving certain fee-for-service regulations that were intended to deter excessive use of health care services, to enable ACOs to use more innovative care management techniques to serve their beneficiaries, and
- extending the time ACOs are allowed to be in a one-sided (“bonus-only”) risk model.

We then comment on the crucial issue of how to set the benchmarks for ACOs. A benchmark is the spending target for a population of attributed beneficiaries. If the ACO achieves that target, it is then eligible for shared savings. In the near-term there is an issue of sustainability connected with the current method of rebasing the benchmark after the first three-year agreement period. We consider several alternatives discussed in the proposed rule and suggest a strategy for rebasing benchmarks.

For the longer-term, we discuss the issue of whether the benchmark should be based on an individual ACO’s historical spending or whether the benchmark should be based on Medicare spending in the market where the ACO is located. We think this decision should be driven by two principles; equity and efficiency. Equity among benchmarks for ACOs in a market means they are starting from the same benchmark correctly adjusted for risk. Efficiency means that the entity that

can achieve the best combination of high quality and low Medicare spending is rewarded. Focused narrowly, that means the most efficient ACO in a market is rewarded. Considered more broadly, it may mean that ACOs, Medicare advantage (MA) plans, and the local fee-for-service delivery system can be compared and the most efficient rewarded. We discuss several ideas for how benchmarks could be computed to put these principles into practice, acknowledging that much analytic work will be needed to do so.

### **Creating a new Track 3 with prospective beneficiary alignment**

The MSSP now has two Tracks that ACOs can join. Track 1 is a one-sided risk model, which means ACOs can share savings with Medicare but are not liable for any losses. Track 2 is a two-sided risk model with both shared savings and shared losses. Almost all ACOs so far have chosen Track 1. Both Tracks have preliminary attribution of beneficiaries that is prospective (i.e., decided prior to the start of the year) but final beneficiary attribution and financial calculations are retrospective (i.e., determined at the end of the year).

CMS proposes the creation of a new Track 3 in the MSSP program. Track 3 would incorporate fully prospective assignment of beneficiaries to the ACO, increase the shared savings rate from 60% to 75%, and widen performance payment and loss sharing limits.

**Comment:** We support this proposal. As we discussed in our June 14, 2014 letter, moving from retrospective to prospective attribution is important for the program because it will enable ACOs to know which beneficiaries they are accountable for at the beginning of the year. This certainty has two benefits. First, ACOs can focus their care coordination efforts on those beneficiaries with the knowledge that they will share in the returns from those efforts; this should increase their willingness to make the investment to improve care coordination. (For this reason, we would also suggest that CMS consider extending prospective attribution to Track 1 and Track 2 as well.) Second, if the beneficiaries are known with certainty and the ACO is in a two-sided model, CMS could grant regulatory relief to those ACOs to pursue more innovative care management. For example, it could allow beneficiaries to be discharged to skilled nursing facilities (SNFs) without meeting the current 3-day inpatient stay requirement or allow ACOs to waive certain cost sharing. (See comment on regulatory relief below.)

## **Providing regulatory relief for ACOs**

CMS is asking for comments on a wide variety of ways to encourage ACOs in the MSSP to move to two-sided risk arrangements. Moving to two-sided risk models provides a stronger incentive to control costs, which in turn creates the opportunity for relief from regulations that were designed to prevent overuse of health care services. The proposed rule discusses waivers associated with the SNF 3-day rule, billing and payment for telehealth services, homebound requirement under the home health benefit, and waivers for referrals to post-acute care settings. It also notes: “Under prospective assignment, beneficiaries would be assigned to the ACO for the entire performance year, and it would thus be clear as to which beneficiaries the waiver applied.”

*Comment:* We agree that Medicare should grant such regulatory relief to ACOs. However, the relief should be limited to ACOs in Track 3; the only Track with fully prospective assignment and two-sided risk. Fully prospective assignment is necessary because CMS must know in advance to which beneficiaries the relief applies in order to process claims appropriately. The ACO must be at two-sided risk because the regulations that are being waived were intended to prevent unnecessary use of health care services and only ACOs at two sided risk have enough of an incentive to offset the FFS tendency to increase use of services. It follows, therefore, that for the waiver to apply, both the beneficiary must be prospectively attributed to a Track 3 ACO and the provider involved (e.g., the physician prescribing direct admission to a SNF) must be a participant of a Track 3 ACO.

We also suggested in our June 2014 letter, that CMS consider allowing ACOs to waive some or all cost sharing for visits with ACO practitioners. Reduced cost sharing is one way of increasing beneficiary identification with the ACO. We have considered in particular eliminating or reducing cost sharing for ACO beneficiaries’ visits to primary care providers who are in the ACO and possibly to specialists in the ACO as well. This would give the beneficiaries a reason to want to be attributed to the ACO and encourage beneficiaries to stay within the ACO network of providers—allowing more effective care management. The cost sharing reduction would be

absorbed by the ACO and not change Medicare program payments.<sup>2</sup> This waiver would be limited to Track 3 ACOs for the same reasons as above and the waiver would be limited to ACO patients seeing ACO providers. The greater patient engagement with ACO providers could contribute to improved care management and make attribution more meaningful.

### **Extending the transition from the one-sided to the two-sided model**

Under current regulations, ACOs in Track 1 (which is a one-sided risk or “bonus only” model) are required to transition to Track 2 (which is a two-sided risk model under which the ACO is liable for losses as well as able to share in savings) after their first 3-year agreement period. CMS proposes to allow ACOs in Track 1 to continue in Track 1 for one additional 3-year agreement period. CMS’s proposal requires that the ACO’s quality performance be reasonable and that its losses have not been excessive in the first two years. In addition, for ACOs approved for a second 3-year period in Track 1, the shared savings rate decreases from 50% in the first agreement period to 40% in the second agreement period.

*Comment:* We support this proposal during this developing phase of the MSSP. In our discussions with ACOs it is apparent that some will not be ready to take on risk after their first three years in the program. As CMS points out, almost all MSSP ACOs have chosen Track 1 and are averse to being at financial risk and many have indicated they would not continue in the program if forced to be at risk in the next performance period. The proposal strikes a reasonable balance between allowing promising ACOs to continue in the program for a limited time without bearing risk and encouraging ACOs to transition to two-sided risk. As we have said in the past, incentives for improvement are much stronger in a two-sided model. Moving to two-sided risk models for ACOs as they gain experience with the program will be important both to strengthen incentives to control costs and to make it possible for CMS to give ACOs more latitude for innovation.

Not all ACOs will be able to make the transition to two-sided risk. However, that should not deter CMS from eventually requiring ACOs that stay in the MSSP to transition to two-sided risk. The goal should not be to maximize the number of ACOs in the program, but rather to encourage

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<sup>2</sup> Benchmarks and expenditures for shared savings calculations would also not change, because they are also based on program spending.

ACOs with a robust ability to improve quality and control spending growth to be in the program and reward them appropriately. We discuss the implications of this principle for setting benchmarks in the next section.

## **Setting benchmarks**

Benchmarks are the spending target for a population of attributed beneficiaries, if an ACO achieves that target it is then eligible for shared savings. We first discuss the near-term issue of sustainability, which arises from the current method of calculating the benchmark for the second three-year agreement period. This is referred to as rebasing the benchmark.

We then discuss the longer-term issue of whether the benchmark should be based on an individual ACO's historical spending or whether the benchmark should be based on Medicare spending in the market where the ACO is located. This issue is important to achieve equity among ACOs in a market and to eventually understand how to reward efficiency among not only ACOs, but also across payment models including fee-for-service Medicare and Medicare advantage (MA).

### ***Near-term issue: Sustainability of current benchmarking model***

The Pioneer demonstration showed that some ACOs were able to reduce the cost of care while maintaining relatively high quality metrics. However, when we interviewed some of these successful ACOs, they were concerned about the sustainability of the ACO model under the current approach for rebasing benchmarks. ACO benchmarks are now rebased for both Pioneer and MSSP in a way that assumes the ACO should be able to continuously improve over its past performance and manage the cost of its aligned population to grow no more than the average growth in FFS.<sup>3</sup> This formula is not likely to be sustainable over the long term, particularly during periods of low FFS growth. For example, if ACOs reduce the spending for their attributed beneficiaries in the current ACO cycle, that would lead to a lower benchmark in the next three-year ACO contract cycle. (Attachment 1 provides an illustrative example of this issue.)

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<sup>3</sup> In the MSSP, the allowed growth rate is the absolute dollar amount of growth in national FFS. In Pioneer it is 50 percent the absolute dollar amount and 50 percent the percentage change in the national amount applied to the ACOs benchmark.

The proposed rule discusses several approaches to address this problem, such as equally weighting the three benchmark years when rebasing the benchmark, accounting for shared savings payments in the benchmarks, using regional factors in establishing and updating the benchmarks, and holding the ACO's historical costs constant relative to its region when rebasing the benchmark.

**Comment:** Each of these proposals has its merits, however to the extent that these approaches raise the benchmarks for all ACOs—even those ACOs that are high-spending—we would not support them. Instead, we would propose that the benchmark for an ACO be rebased unless that ACO passes a two-part test. First, per-capita spending for the ACO (after that spending is adjusted for health care risk and input prices) must be below the national average per-capita FFS spending. Second, per-capita spending for the ACO (risk adjusted) must be below the average FFS spending (risk adjusted) in the ACO's market. This would serve to diminish the difference in benchmarks between high and low-spending ACOs and encourage the latter. The benchmarks for lower-spending ACOs could be left unchanged (except for trend) at the end of the first agreement period. This approach might reduce some ACOs' concerns that they are being unfairly treated due to past success in reducing spending.

***Longer-term issue: Historical vs. regional benchmarks***

In the longer-term, the key issue for setting benchmarks is raised in the section entitled ***Alternative Benchmark methodology: transitioning ACOs to benchmarks based only on regional FFS costs over multiple agreement periods***. Should ACO benchmarks continue to be set based on the historical expenditures of the ACO's beneficiaries or should they be set based on regional FFS expenditures? How this question is answered will determine if ACOs that are efficient in their area will tend to succeed or fail. It will also determine what approach to risk adjustment should be followed and how quality bonuses or penalties should be calculated. Therefore, we focus the remainder of our comments on this issue.

**Discussion:** Basing ACO benchmarks on historical experience (per current law) has the advantage of setting what should be an achievable target for the ACO; its historical experience trended forward by the growth in FFS at the national level. The logic is that if the ACO can beat the national trend, it can share the savings with CMS because spending for its beneficiaries will be less than it would have been if the ACO did not exist. It also would appear to simplify risk-adjustment,

in that past spending is a good predictor of future spending. Starting with past experience also gives high-spending ACOs a reason to join because they should have plenty of scope to reduce spending. Also, ACOs that have been restraining spending growth relative to the national average, if they can continue to do so, should be successful as well. Thus, a benchmark based on an ACO's past spending was a reasonable starting point when the program began.

However, the contradictions of basing ACO benchmarks on past spending are becoming apparent. The proposed rule raises two issues. First, as already discussed, there is the issue of what to do in subsequent agreement periods. If initial benchmarks were based on past spending, and that model is followed in subsequent agreement periods, the benchmarks for successful ACOs could decline rapidly and no longer represent achievable targets. Second, efficient ACOs that had already been achieving low spending relative to others in their areas would be placed at a continuing disadvantage and would face the prospect of ever lower benchmarks compared to other ACOs in their area. A third issue is that an ACO will often be in the same market with not only other ACOs but also MA plans, yet it may have a very different benchmark from all of those entities and that could have undesirable results.

### ***Principles for computing benchmarks***

The proposed rule explores several options and captures much of the argument for and against transitioning to local FFS from historical benchmarks. We would urge CMS to keep the following principles in mind when considering alternatives:

- There should eventually be equity among benchmarks for ACOs in the same area. This is important because more efficient (higher-quality and lower-spending) ACOs should be rewarded and providers and beneficiaries encouraged to join them. Equity means starting with equal benchmarks in an area, properly adjusting for risk, and protecting against differences in coding.
- The goal is not to create as many ACOs as possible: the goal is to create the conditions that will allow efficient ACOs to be successful. In the long-term, equitable benchmarks across payment models should help to determine if ACOs are a more efficient organization for the delivery system than MA plans or the other FFS providers in an area. We do not envision ACOs as the most successful option in all markets; there will be some markets where MA

plans dominate and others where FFS dominates (please see MedPAC's June 2014 report to the Congress).<sup>4</sup> The program, beneficiaries, and providers will benefit if the ACO benchmarks relate to those used in MA and to FFS spending in an area. Ideally, that would enable providers to choose how to organize most efficiently and beneficiaries to choose a plan or provider that best meets their needs.

**Comment:** With these principles in mind, MedPAC favors eventually moving ACOs to a common benchmark in a market as we describe in the following paragraphs. Perpetuating differences between benchmarks for inefficient and efficient ACOs cannot be considered to be equitable in the long-run; thus moving to equitable benchmarks in a market is necessary. Equitable benchmarks will have to be based on some standard. As a starting point for this discussion, we will consider local FFS spending (where FFS spending is defined to include spending on beneficiaries in ACOs as well as on beneficiaries in traditional FFS) as the standard for the benchmark in a market. This is in some sense a financially neutral target and thus a reasonable starting point.

This common benchmark approach would have the ancillary benefit of removing some of the complications introduced by changes in the payment systems that are outside the provider's control but affect local FFS spending. For example, changes in the local area wage index.<sup>5</sup> Because the benchmark would be based off of local FFS spending, to the extent that local FFS spending would be affected by those payment system changes, it would be reflected in the benchmark. A technique similar to that taken in MA to correct for payment system changes could be followed when setting ACO benchmarks as well.<sup>6</sup> Moving toward basing ACO benchmarks on local FFS spending (or another common benchmark) has implications for several aspects of the MSSP including risk adjustment, rewarding quality, and computing program savings.

*Risk adjustment.* The method of risk adjustment should be informed by the choice of benchmarking methodology. We have discussed that historically-based benchmarks essentially

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<sup>4</sup> MedPAC. *Report to the Congress: Medicare and the health care delivery system*. June 2014. [http://medpac.gov/documents/reports/jun14\\_entirereport.pdf?sfvrsn=0](http://medpac.gov/documents/reports/jun14_entirereport.pdf?sfvrsn=0)

<sup>5</sup> For example, the wage index for California hospitals increased relative to the national average in 2013. Because the trend used is the national trend, this made the benchmark more difficult to achieve for California ACOs that used those hospitals than for ACOs in other areas where the wage index was unchanged or decreased.

<sup>6</sup> In the MA program an average of the last five years of FFS spending is computed for each county. To correct for payment rule changes, CMS recomputes past spending by substituting current payment rules.

incorporate risk adjustment because past spending is a good predictor of future spending. Thus, the design of risk adjustment in MSSP primarily uses demographic risk adjustment for continuously enrolled beneficiaries. Simply put, it is intended to allow for increased spending due to the effects of the population aging, but not because the population is getting sicker than expected.

If ACOs move to a local FFS based benchmark (similar to MA), those benchmarks will have to be risk adjusted for the population in each ACO.<sup>7</sup> The way this is done in the MA program is through the use of the hierarchical condition category (HCC) scores for each beneficiary. In MA, Medicare pays more for a beneficiary with a higher risk score than for a beneficiary with a lower risk score. Thus, MA plans have an incentive to code beneficiaries as high as possible. To correct for average differences in coding between MA and FFS, reported MA risk scores are reduced by a single nationwide amount. For ACOs, a possible alternative to this single nationwide adjustment could be to limit the growth in HCC scores for beneficiaries that have been assigned to an ACO for more than one year. A beneficiary would enter the ACO with a risk score. Then each year that risk score would be increased to reflect the expected change in costliness given the beneficiary's initial risk score, age, and other characteristics. Additional coding would not affect the risk score. Under this alternative, ACOs should have no incentive to increase their beneficiaries' risk scores; instead, they should have a strong incentive to keep their beneficiaries healthy and to retain those beneficiaries from year to year.

*Rewarding high quality.* Although we will not address quality issues in this letter (see comment on ACO quality in MedPAC's comment letter on the physician fee schedule rule),<sup>8</sup> we would note that moving to a common FFS-based benchmark for ACOs and possibly MA plans also will raise an issue about how quality scores should affect payment. Currently in the ACO program, if an ACO does as well as possible on quality, then the savings rate is not decreased, while any lower score results in a lower savings rate; this is essentially a penalty only model. In contrast, in the MA

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<sup>7</sup> The adjustment may also have to take into account the differences between the population of beneficiaries eligible for attribution and the population of beneficiaries who are not. Because the ACO's population is limited to the former, its benchmark calculation may need to reflect that fact.

<sup>8</sup> *MedPAC comment on CMS's proposed rule entitled: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the CMMI Models & Other Revisions to Part B for CY 2015.* August 28, 2014. [http://medpac.gov/documents/comment-letters/08282014\\_comment\\_letter\\_2015\\_pt\\_b\\_rule\\_final.pdf?sfvrsn=0](http://medpac.gov/documents/comment-letters/08282014_comment_letter_2015_pt_b_rule_final.pdf?sfvrsn=0)

program better quality performance is rewarded with a higher benchmark; this is a bonus-only model. If both MA and ACOs are going to have a common benchmark in a market, then it may be necessary for quality to be similarly rewarded for both models. (For example, quality bonuses could be given to ACOs and MA plans with quality better than FFS and penalties collected from ACOs and MA plans with quality lower than FFS.) Otherwise, the ACO with top quality performance would end up with a lower benchmark than an MA plan in the same market with top quality performance. That situation could be seen as inequitable for the ACO.

*Program savings.* There will be tension between the move to a FFS-based benchmark and the need for the ACO program to save money for the Medicare program. With a historically-based benchmark, the case for budget savings hinges on the argument that spending in the absence of the ACO program would have been historical spending trended forward by the change in national average FFS spending and that anything less than that is a savings for the program. That is, if the providers in high-spending ACOs had continued their previous practice patterns, spending would have continued to increase at the national FFS growth rate. Under that system, high-spending ACOs may well produce the most savings. But by setting a benchmark based on local FFS, ACOs will know in advance what the target will be and could select in or out of the program accordingly. For example, the high-spending ACOs may just stay out of the program, believing that the benchmark is unobtainable for them. From a short-term perspective, if the low-spending ACOs enter, they will not necessarily save money relative to their expected spending. They will save relative to local FFS, but if their spending was going to be below that anyway, they will not necessarily save relative to expected spending for their beneficiaries.

A longer term perspective on possible program savings could yield a different answer. Low-spending ACOs might attract providers and beneficiaries. Providers might be attracted by the shared savings the ACO earns in the hope of sharing those savings themselves and by the availability of additional resources for care coordination. Beneficiaries would often stay with their providers and thus migrate to the ACO with them. In addition, if the ACO offers higher quality or lower copays for some services, beneficiaries may move to ACO providers. If those providers adopt an efficient practice style and beneficiaries like the ACO, then there may be savings relative to what spending would have been if those providers and beneficiaries were not in the ACO.

However, it will more difficult to estimate these long-term savings. Because the statute requires savings at least equivalent to the original ACO model, this issue is important.

*Transitions.* If the eventual goal is a market-level benchmark based on local FFS spending, then the design of benchmarks in the interim should take that into account and a transition path will need to be determined. The proposed rule raises a number of issues related to transition including how many agreement periods would be considered for the transition. An additional issue that arises is: should there be a specific date when benchmarks for all ACOs will be based off of local FFS? That is, even a new ACO would face the same benchmark as others in its market. This would simplify the system and would also prevent a situation in which ACOs might be tempted to disband and reorganize as a new ACO to create a new historically-based benchmark.

As a starting point, we would suggest that ACOs in two-sided models transition to area FFS-based benchmarks by the end of their second agreement period, which would be at the end of six years in the program. The transition could start in year 1 of the second period and be completed by year 3. In addition, all ACOs should face the area FFS-based benchmarks by the year 2021, which would be the 6<sup>th</sup> year for an ACO starting in 2016. This would give CMS several years to establish regulations for the new approach. This will be needed because certain aspects of risk adjustment will require additional analytic work to be done.

*Summary.* MSSP should transition from historically based benchmarks unique to each ACO to an equitable benchmark for each market based on FFS spending in that market. This would provide equity and encourage efficient ACOs. As efficient ACOs increase their population of aligned beneficiaries the benchmark for that area will reflect the ACOs' experience. That is, the benchmarks would be calculated on the Medicare spending for all FFS beneficiaries in the area, including those in ACOs. If ACOs lower spending growth, benchmarks will be lower than they would have been. This should reduce Medicare spending directly for beneficiaries in efficient ACOs and indirectly by lowering the benchmark for MA plans. ACOs should transition to those benchmarks over the three years of their second agreement period or by 2021 whichever is sooner.

## Conclusion

We support CMS's proposal to create a new Track 3 with prospective attribution of beneficiaries and two-sided risk. We also support providing regulatory relief to Track 3 ACOs to provide for more innovative care management and extending the transition period for ACOs in the one-sided risk model. We concur that improvements need to be made now in the method used to rebase benchmarks in the MSSP program to improve the program's sustainability. In the longer term, the basis for setting benchmarks for MSSP ACOs needs to be rethought. The principles for setting the benchmarks are straightforward: equity and affording a clear comparison among ACOs, MA plans, and FFS in an area. Starting from those principles we conclude that MSSP ACOs should have a common benchmark in a market and that benchmark should eventually be based on local FFS spending rather than individual ACO's historical experience. Creating detailed regulations to make this change will be challenging, but could be accomplished in future rulemaking and many aspects have already been contemplated in the proposed rule.

The MSSP is at a critical stage: while many ACOs have joined the program and it has considerable momentum, issues about how to set benchmarks and other aspects of the program have become more apparent. It is time to set a clear path forward for the program. MedPAC appreciates your consideration of the policy issues we have discussed as CMS moves toward a final rule. The Commission values the ongoing cooperation and collaboration between CMS and MedPAC 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,



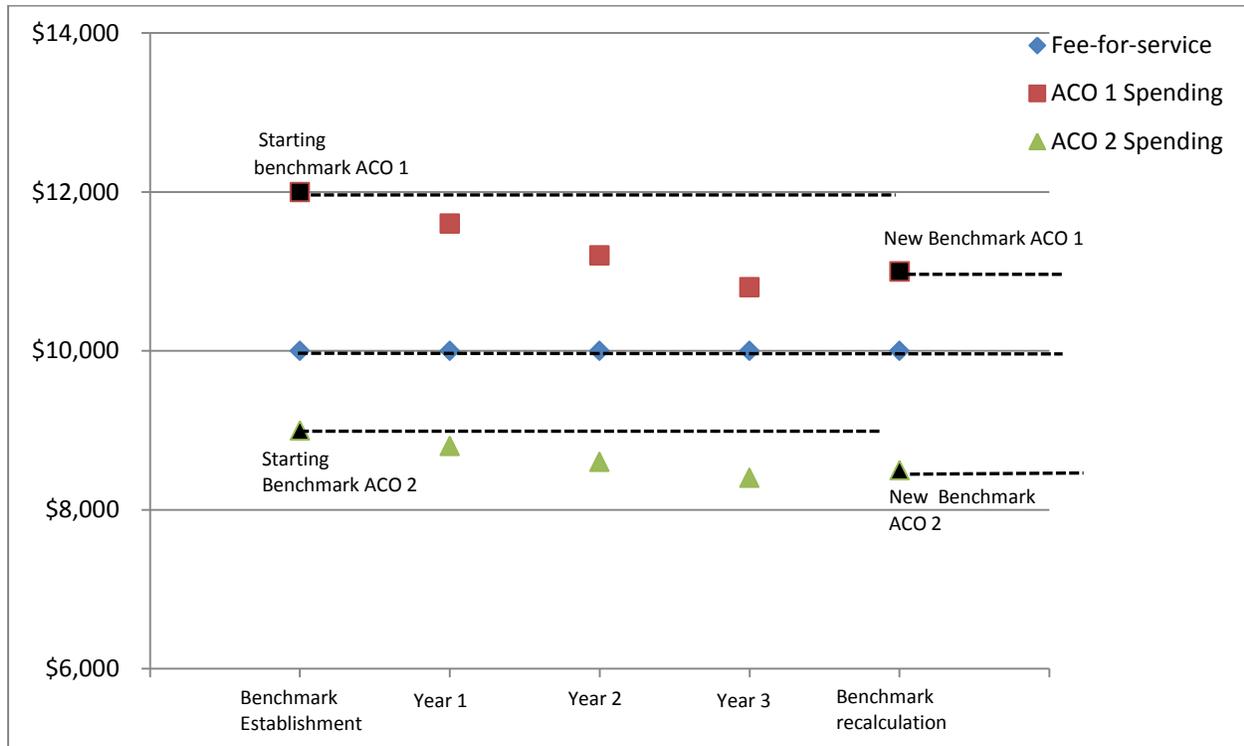
Glenn M. Hackbarth, J.D.  
Chairman

## **Attachment 1: Illustrative example of rebasing benchmarks under current rules.**

Under current rules, if an ACO continues in the ACO model beyond the first agreement period its benchmark is rebased for the second agreement period based on the Medicare spending for its beneficiaries in the first three-year agreement period. Specifically, a weighted average of the spending is computed weighting Year 1 at 0.1, Year 2 at 0.3, and Year 3 at 0.6. The result is if an ACO is successful and reduces spending in the first three years, its benchmark for the agreement period starting in year 4 will be lower than it was for the first agreement period (absent trend). ACOs have questioned whether this model is sustainable.

Figure 1 illustrates the problem. In figure 1, we provide a simplified illustrative example of a market with two ACOs. ACO 1 is a high-spending ACO that starts with a benchmark of \$12,000, ACO 2 is a low-spending ACO that starts with a benchmark of \$9,000, and the FFS average per-capita spending in the market is \$10,000. In this simplified example, we assume that the ACO populations and the area's FFS population all have similar health care risk and we set the growth trend each year at zero. Also, we assume each ACO has good quality. Each ACO achieves its spending target. ACO 1 reduces per-capita spending by \$400 each year, so in year 3 its spending per-capita is \$10,800; \$1,200 less than its original benchmark. ACO 2 also reduces spending, but by \$200 a year, in year 3 its per-capita spending is \$8,400. Using current rules, the benchmark for the next agreement period would be \$11,000 for ACO 1 and \$8,500 for ACO 2. The average FFS spending in the market would still be \$10,000.

**Figure 1. Illustrative example of rebasing benchmarks for two ACOs in a market under current rules**



ACO 2 was efficient to begin with, that is, it was caring for an equally risky population, achieving good quality, and Medicare was spending less (\$9,000) for their care than it was for other beneficiaries in that area (\$10,000). The new benchmark (\$8,500) requires ACO 2 to now care for those patients for that amount and fund their care coordination efforts and administrative costs with shared savings calculated against that lower benchmark. That may not be sustainable. In addition, their competitor ACO 1 has a much higher benchmark (\$11,000); that does not appear to be equitable.