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October 15, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

Re: File code CMS-1701-P

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Medicare proposed rule entitled: *Medicare Program: Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success* (*Federal Register*, page 41786, volume 83, number 160, August 17, 2018). The rule proposes major changes to the Medicare Shared Savings Program (MSSP). In view of the complexity of the accountable care organization (ACO) program and the demands on your staff's time, we appreciate the efforts you are taking to improve the program.

On balance, the proposed rule represents a major advance for the MSSP, and the Commission supports many of the proposals, in particular the proposed “glide path” toward two-sided risk models. Two-sided risk models are those in which the ACO shares in savings if actual spending is lower than the benchmark, and shares in losses if actual spending is higher than the benchmark. (In contrast, under a one-sided risk model an ACO can share in savings but has no liability for losses.) The Commission has long supported moving ACOs to two-sided risk models with prospective assignment because they provide stronger incentives for ACOs, protect the Medicare trust funds, and make it possible to provide regulatory relief—and thus more innovative care delivery models. The Commission has stated this position in numerous reports to the Congress and comment letters on ACO regulations.¹

A recent study suggests that the benefit the Medicare program derives from one-side risk ACO models is larger than the difference between ACO benchmarks and spending might indicate,

¹ Medicare Payment Advisory Commission. 2015. Comment letter to CMS on Medicare Shared Savings Program: Accountable care organizations proposed rule. February 2. Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

prompting the authors to call for a longer glide path for one-sided ACOs.² But two-sided risk models provide stronger long-term incentives for ACOs to make practice pattern changes that improve quality and reduce costs. For example, practice pattern changes could include efforts to better manage transitions of care and help beneficiaries choose higher quality and lower cost post-acute care. In two-sided models, those efforts will be rewarded with higher rates of shared savings than in one-sided models, and failure to make such changes could well result in shared losses. Two-sided models also help protect the Medicare trust funds. For example, in a two-sided model, *savings* resulting from random variation are balanced by shared *losses* from random variation; in a one-sided model, they are not. Further, in a one-sided model, regulatory relief—such as waivers of anti-kickback rules—intended to spur innovative changes in the delivery system might instead have the unintended effect of increasing the volume of services. This is because, in a one-sided ACO model, the persistent incentive in the fee-for-service (FFS) system to increase volume will not be balanced by the responsibility for total Medicare spending inherent in two-sided ACO models. In the Commission’s view, relief from regulations designed to counter the FFS incentive to provide more services should be extended only to ACOs at two-sided risk.

For the first six years of the MSSP program, providers were not required to transition to two-sided risk. The proposed rule would require that a gradual movement toward two-sided risk start in the middle of 2019. However, a two-sided risk model need not require an ACO to take on an inordinate amount of risk. For example, by the end of the first five years in the BASIC track, the proposed model has a limited level of downside risk and higher shared-savings rate than shared-loss rate. Thus, although ACOs will have to take on risk in the proposed model, that risk is constrained. In the end, providers may be willing to accept a gradual movement to two-sided risk in exchange for the potential of greater upside gain.

In this letter we comment specifically on the following proposed changes:

- The “glide path” toward two-sided risk for ACOs
- Favoring “low-revenue” ACOs over “high-revenue” ACOs
- Allowing ACOs to choose prospective or retrospective assignment of beneficiaries into the ACO
- Blending of benchmarks based on historical and regional spending
- Allowing risk scores of existing ACO beneficiaries to increase faster than the national average, with a cap on growth of 3 percent
- Allowing beneficiaries to opt into ACOs

Proposed change: Defines a “glide path” for ACOs to bear downside risk

CMS proposes to discontinue the current MSSP tracks (Tracks 1, 2, and 3), and the Track 1+ ACO model and replace them with two new tracks for ACOs. The first new track for ACOs is a BASIC

² McWilliams, J.M., L.A. Hatfield, et al. 2018. Medicare spending after 3 years of the Medicare Shared Savings Program.” *New England Journal of Medicine* 379:1139–49.

MSSP track that has a five-year contract, starts with one-sided (bonus only) risk, and gradually moves toward two-sided asymmetric risk similar to the current Track 1+ ACO model. The second track, called the ENHANCED track, has two-sided risk for the full five years of the ACO contract and is equivalent to the current Track 3.

The BASIC track starts at Level A (lowest risk) and automatically progresses up a level each year to Level E in the fifth year (highest risk). Levels A and B have a shared savings rate (SSR) of 25 percent and no downside risk. Level C has a SSR of 30 percent, Level D 40 percent, and level E 50 percent. In all levels the cap on shared savings is 10 percent of the benchmark. Levels C, D, and E all have a shared loss rate of 30 percent, but the maximum loss becomes progressively higher. Level E is equivalent to the current Track 1+, and the maximum loss is currently 8 percent of the participant’s FFS revenue or 4 percent of the benchmark, whichever is less. (The maximum loss amount in Level E is defined to meet CMS’s standard for nominal risk under the Quality Payment Program. This allows the model to qualify as an Advanced Alternative Payment Model. In the proposed rule, if CMS changes the nominal risk standard, the maximum loss amount in Level E will change automatically to match it.) Under the proposed rule, ACOs would have no downside risk for at most two years. (See Table 1 for details). This contrasts with the current model, which allows two three-year contracts with no downside risk.

The ENHANCED Track is equivalent to the current Track 3 in levels of risk. The shared savings rate is up to 75 percent, not to exceed 20 percent of the benchmark. The loss rate is 1 minus the final shared savings rate with a minimum of 40 percent and maximum of 75 percent, not to exceed 15 percent of the benchmark. Both proposed tracks have asymmetric risk with greater upside than downside risk (Table 1).

Table 1. Proposed tracks for MSSP ACOs

	BASIC Track Glide Path				ENHANCED Track
	Level A & Level B (one-sided model)	Level C (risk/reward)	Level D (risk/reward)	Level E (risk/reward)	
Shared savings (once MSR met or exceeded)	1st dollar savings at a rate of up to 25% based on quality performance, not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 30% based on quality performance, not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 40% based on quality performance, not to exceed 10% of updated benchmark	1st dollar savings at a rate of up to 50% based on quality performance, not to exceed 10% of updated benchmark	No change. 1st dollar savings at a rate of up to 75% based on quality performance, not to exceed 20% of updated benchmark
Shared losses (once MLR met or exceeded)	N/A	1st dollar losses at a rate of 30%, not to exceed 2% of ACO participant	1st dollar losses at a rate of 30%, not to exceed 4% of ACO participant revenue capped	1st dollar losses at a rate of 30%, not to exceed the percentage of revenue specified in the revenue-based nominal amount	No change. 1st dollar losses at a rate of 1 minus final sharing rate (between 40% - 75%), not to

		revenue capped at 1% of updated benchmark	at 2% of updated benchmark	standard under the Quality Payment Program (for example, 8% of ACO participant revenue in 2019–2020), capped at a percentage of updated benchmark that is 1 percentage point higher than the expenditure-based nominal amount standard (for example, 4% of updated benchmark in 2019–2020)	exceed 15% of updated benchmark
Advanced APM status?	No	No	No	Yes	Yes

Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization), MSR (minimum savings rate), MLR (minimum loss rate), Advanced APM (Advanced Alternative Payment Model).
 Source: CMS, *Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success* proposed rule.

As a result of these major changes, the proposed start date for the new ACOs is July 1, 2019. To accommodate this mid-year start, the two tracks would have an initial five-year, six-month agreement period. Future contracts would be for a five-year period. There will be no new ACOs on January 1; however, those ACOs ending their current agreement period on December 31, 2018, can extend six months.

The net result of replacing Track 1 and Track 2 ACOs with the new BASIC track is that ACOs will be required to bear two-sided risk on a faster timetable than is required under current policy. CMS estimates that this will cause ACOs that are not confident in their ability to achieve savings to drop out of the program or not enter it. CMS projects that by 2028 there will be 109 fewer ACOs in MSSP than would have been in the program under current policy. However, CMS also projects that moving from one-sided to two-sided models and the other proposed changes will lower program spending by \$2.24 billion between 2019 and 2028.

CMS also proposes to terminate ACOs with poor financial performance over two years. Specifically, “if the ACO is negative outside corridor for a performance year, we propose that we may take any of the pre-termination actions set forth in §425.216. If the ACO is negative outside corridor for another performance year of the ACO’s agreement period, we propose that we may immediately or with advance notice terminate the ACO’s participation.” The stated purpose of the terminations would be to remove ACOs that are not in the program to improve quality and reduce cost, but rather for other factors such as “receipt of program data and the opportunity to enter into

certain contracting arrangements with ACO participants and ACO providers/suppliers” (proposed rule, page 41836).

Comment

The proposed redesign of the MSSP program is broadly consistent with the Commission’s position that ACOs should eventually transition to two-sided risk.³ It provides a gradual path to risk and stronger incentives for ACOs to change practice patterns and invest in care coordination. As the proposed rule notes in the regulatory impact analysis, there would be fewer ACOs than otherwise might be anticipated under current policy in the MSSP, but those that are in the MSSP would be more likely to control expenditures for the Medicare program and make real efforts to improve care. As we have stated in the past: “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.”⁴ The Commission therefore supports the proposed glide path.

However, CMS may want to consider modifying its proposal by increasing the shared savings rates in the BASIC track. The proposed shared savings rates in the BASIC track are 25 percent in Level A and B, gradually increasing to 50 percent in Level E. The low rates in the first years could discourage ACOs that might be good candidates from participating in the BASIC track. It might be difficult for ACOs to justify making the investments necessary to organize and improve care if the shared savings rates are that low. Increasing the shared savings rate to 50 percent may increase participation by ACOs. The increase must be balanced against the risk to the Medicare program of paying for random variation in the one-sided models. Because the ACOs would only be in one-sided models for two years, there would be minimal risk to Medicare from increasing the shared savings rates and doing so might encourage ACOs to enter the program and make the investments necessary to succeed.

Another modification CMS should consider is that, if ACOs are taking two-sided risk, they should not be required to leave the program if they are not generating savings for one or two years. For many smaller ACOs (those with under 20,000 beneficiaries), there is expected to be substantial random variation in spending. In some years, they will generate shared savings and in others they will generate shared losses. If an ACO is improving the efficiency of care delivery, eventually its shared savings will outweigh its shared losses. One or two years of shared losses cannot be seen as a definitive indicator of performance given the small number of beneficiaries in most ACOs.

With these modifications to the proposed shared savings rates, and eliminating the requirement to achieve savings, the proposed glide path would achieve a better balance between encouraging participation by ACOs and creating the conditions for ACOs to have the incentives to succeed. The Commission supports the glide path and its movement toward two-sided risk; the glide path would be strengthened by these modifications.

³ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

⁴ Medicare Payment Advisory Commission. 2015. Comment letter to CMS on Medicare Shared Savings Program: Accountable care organizations proposed rule. February 2.

Proposal: Favoring “low-revenue” ACOs over “high-revenue” ACOs

In the rule, CMS defines a “low-revenue” ACO as having Medicare FFS revenue of less than 25 percent of the Medicare Part A and Part B spending of its attributed beneficiaries and a “high-revenue” ACO as one that has FFS revenue of greater than or equal to 25 percent of its attributed beneficiaries’ spending. CMS makes this distinction on the assumption that a low-revenue ACO is less financially capable of taking on risk than a high-revenue ACO. (As the proposed rule shows in its analysis, low-revenue/high-revenue is a proxy for clinician-only ACOs and ACOs with both clinician and hospital participants.) The proposed rule further states that “it becomes clear that low-revenue ACOs are saving CMS money while high-revenue ACOs are resulting in additional spending by CMS before accounting for market-wide and potential spillover effects” (proposed rule, page 41917).

CMS uses the greater savings from low-revenue ACOs and the lower ability of these ACOs to take on risk to justify favorable treatment. In the rule, a low-revenue ACO can be in the BASIC track for two agreement periods, while a high-revenue ACO cannot. (Former Track 1 ACOs are allowed one year in the BASIC track at the B Level of risk sharing, and then must transition through the other levels and have two years at the Level E of risk sharing.)⁵

Comment

We do not support more favorable treatment of low-revenue ACOs or making a distinction between low- and high-revenue ACOs for payment purposes. If high-revenue ACOs in the one-sided ACO model (Track 1) are resulting in additional Medicare spending, they should be moved into two-sided models, which will prevent them from further increasing spending. The new glide path will do that. If low-revenue (or physician-only ACOs) expect to achieve savings, they should be willing to move into the Level E model in the glide path, which has minimal risk and potentially greater reward.

In addition, Level E (the Track 1+ model) in effect already favors lower-revenue ACOs. This is because in Level E the maximum loss amount is the lower of 8 percent of the ACO’s participants’ FFS revenue or 4 percent of the ACO’s benchmark. For a low-revenue ACO, 8 percent of its participants’ FFS revenue will be lower than 4 percent of the ACO’s benchmark. Thus, it will have less at risk than a high-revenue ACO. Moreover, a physician-only ACO could benefit even more if its participating clinicians receive the A–APM incentive payment. That payment is 5 percent of each clinician’s professional services revenue. This would essentially reduce the ACO’s collective maximum risk to 3 percent of its Medicare FFS revenue (8 percent minus 5 percent). Thus, CMS does not need to explicitly recognize or reward low-revenue ACOs in Level E; they already are advantaged by the terms of the model and its intersection with the A–APM incentive.

⁵ The proposed rule also distinguishes between ACOs that are experienced with performance-based risk ACO initiatives and those that are not. Inexperienced ACOs can start BASIC in Level A, experienced must start in Level E or go directly to ENHANCED.

Favoring ‘low-revenue’ ACOs over ‘high-revenue’ ACOs, or physician-only ACOs over ACOs that include hospitals, is not necessary and could lead to unintended consequences. Although low-revenue or small ACOs may be less able to absorb risk, their maximum risk may in fact be quite limited in some cases. In addition, they could conceivably partner with a larger organization that could absorb the financial risk, such as an ACO aggregator. The concern about unintended consequences is that a high-revenue ACO could be encouraged to selectively redefine its component tax identification numbers (TINs) to change itself into a low-revenue ACO. For example, an ACO with a common TIN for its hospital and its physician practice could create separate TINs for each and drop the hospital TIN from the ACO. Thus, we do not support creating the distinction between high- and low-revenue ACOs and treating them differently. It would be better not to extend preferences to any one model of ACO and instead let the market determine the best form for the local area.

Whether or not low-revenue (or physician-only) ACOs are saving more money than integrated hospital–physician ACOs is an important question but does not justify favorable treatment. Physician-only ACOs have, in effect, a larger incentive to reduce hospital-provided services than physician–hospital ACOs because those services represent forgone revenue for the hospital. Therefore, one might expect physician-only ACOs to be more successful at reducing hospital admissions or emergency room use. The proposed rule finds greater savings relative to benchmarks from low-revenue ACOs in 2016, but the analysis may not present the full picture because it does not take into account the fact that physician-only ACOs are more common in markets where service use per beneficiary has been historically high. We previously found that the historical level of service use in the area where the ACO is located was a larger factor than physician-only participation for predicting ACO savings relative to benchmarks in earlier years of the program.⁶ More recent literature, which computes savings relative to a counterfactual (that is, relative to what spending would have been for beneficiaries assigned to ACOs if those ACOs had not existed), finds greater savings from physician-only ACOs.⁷ However, even if physician-only ACOs generate some small degree of additional savings on average compared to hospital-based ACOs, the magnitude of the savings is not large enough for the Medicare program to favor physician-only ACOs over integrated physician–hospital ACOs for payment purposes. Rather, Medicare should be neutral to the specific configuration of ACOs, and instead design and implement policies to reward the most effective ACOs in a given market.

If the program is neutral to high- and low-revenue ACOs, the question arises: Would all ACOs be allowed to stay in the BASIC track Level E for five more years as proposed for low-revenue ACOs, or would they have to move to the ENHANCED track as proposed for high-revenue ACOs? Because the ENHANCED track has stronger incentives for cost control, an argument can be made that all ACOs should move to the ENHANCED track after one five-year period in the basic model. This would be consistent with CMS’s proposal for high-revenue ACOs. However, if CMS concludes that ACOs with a low-level of risk (e.g., one-sided ACOs and Track 1+ ACOs) have generated savings for the Medicare program, all ACOs could be allowed to operate in the

⁶ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

⁷ McWilliams, J.M., L.A. Hatfield, et al. 2018. Medicare spending after 3 years of the Medicare Shared Savings Program.” *New England Journal of Medicine* 379:1139–49.

BASIC track for two five-year periods—which would be consistent with CMS’s proposal for low-revenue ACOs. That policy would allow ACOs five additional years in which risk is limited to Level E risk (8 percent of the ACO participants’ Medicare revenue in many cases). Level E is a two-sided model and is consistent with the Commission’s position that ACOs should be in two-sided models. In addition, although it has enough downside risk to encourage ACOs to control costs, the modest level of risk in the model may be more palatable to a wider range of ACOs.

Proposed change: Allow ACOs to choose retrospective assignment

CMS proposes to allow ACOs to choose each year between prospective and retrospective assignment of beneficiaries into the ACO.⁸ The Bipartisan Budget Act (BBA) of 2018 gives ACOs in Track 1 and Track 2 (which currently have retrospective assignment) the opportunity to choose *prospective* assignment starting January 1, 2020. However, Track 1 and Track 2 ACO models (those with retrospective assignment) are eliminated under the proposed rule. Therefore, the provision would be moot if CMS were to require prospective assignment in both tracks of the redesigned program. Instead, CMS proposes to implement this provision by giving ACOs the choice to move from prospective assignment to retrospective assignment, a choice not contemplated by the provision in the BBA.

CMS proposes this choice in response to comments on previous rules asking for more flexibility on assignment. But previously CMS pointed out that it would be administratively burdensome to do so. For example, in the proposed rule CMS discusses how the baseline for an ACO will have to be recomputed each time the ACO switches assignment methodology.

Comment

The Commission does not support allowing ACOs to choose retrospective assignment. The proposal would increase complexity, lead to inappropriate incentives, and reduce incentives for ACOs to generate enough patient satisfaction to maintain relationships with high-need patients. As we discussed in our 2015 comment letter, a better alternative is to require prospective assignment of all ACO beneficiaries.⁹

Prospective assignment will reduce complexity for several reasons:

- It identifies the beneficiaries for whom the ACO is responsible at the start of the year.
- Patients now have the option of voluntarily assignment to an ACO by selecting a primary care physician. Aligning the voluntary election process and claims-based assignment on a prospective basis would contribute to this certainty.

⁸ We use the term *retrospective assignment* as shorthand for “preliminary prospective assignment with retrospective reconciliation.” It means that assignment is based on the beneficiaries’ claims during the performance year rather than claims in the year preceding the performance year.

⁹ Medicare Payment Advisory Commission. 2015. Comment letter to CMS on Medicare Shared Savings Program: Accountable care organizations proposed rule. February 2.

- It makes it possible to know which beneficiaries are in the ACO and are eligible for waivers such as the 3-day SNF policy and telehealth.

Prospective assignment also reduces inappropriate incentives for two reasons:

- Retrospective assignment encourages ACOs to shift patients to non-ACO doctors if they have an anticipated need for an expensive procedure such as a knee replacement. This is because the patient will lose assignment to the original ACO and the expense of the procedure will no longer be the ACO's responsibility. ACOs with prospectively assigned patients do not have that incentive because the patient's spending for the entire year is the ACOs responsibility regardless of where the patient gets care.
- Under retrospective assignment, an ACO has an incentive to spend money attracting healthy patients who do not need services, such as by offering rewards (e.g., gift cards) to beneficiaries to come in for a visit at the end of the year (e.g., a wellness visit) if they have not received any care that year. This keeps the patient assigned to the ACO and the ACO knows spending for that patient for the year will be very low.¹⁰

Finally, prospective assignment rewards ACOs that build patient loyalty. The ACO is responsible for care provided for the entire year and likely in the following year and thus has a strong financial incentive to create enough patient satisfaction so that the patient remains with that ACO rather than move on to using other physicians. We strongly oppose the proposal to allow ACOs to choose retrospective assignment.

Proposed change: Create benchmarks based on a blend of the historic spending on the ACO physicians' patients and regional spending levels

CMS proposes using a blend of historical ACO spending and regional FFS spending to set initial and rebased ACO benchmarks, with a maximum weight placed on the regional adjustment of 50 percent. (The blend varies over time and by the relation of ACO spending to regional spending.) Under current policy, CMS bases initial ACO benchmarks (those at the beginning of an ACO's first contract period) on the historical level of costs of patients assigned to physicians in the ACO's tax identification number(s). CMS computes rebased benchmarks (those at the start of a subsequent contract period) on a blend of historical and regional spending.

These two different approaches (historical vs. regional FFS spending) arise because repeatedly rebasing benchmarks on the ACO's own historical costs is unsustainable in the long run: As ACO performance improves over time, benchmarks for future performance years reflect that improved performance and become more difficult to meet. An alternative to using ACOs' historical data to set benchmarks is to use regional spending as the benchmark. However, a problem with using only

¹⁰ This incentive could also complicate future evaluations in which a comparison group of patients is assigned to non-ACO physicians. Beneficiaries who are not in ACOs and who had little or no care in the prior months will not be paid by their doctor to come in at the end of a year and could have no physician visit as a result. Beneficiaries who have not had a physician visit are not assignable to a physician and thus will not be in the comparison group. Thus, low-cost beneficiaries who would be included in an ACO will not be included in the comparison group, potentially making ACOs look more effective.

regional spending is that historically low-spending practices could reap large shared savings payments without changing behavior, while practices that serve high-cost beneficiaries may drop out of the ACO program.

In addition to setting initial and rebased benchmarks, CMS updates benchmarks each year to reflect expected growth in spending. To update benchmarks from year-to-year, the rule proposes to use a trend factor that is a blend of regional trends in spending growth and national trends in spending growth. (Under current policy, only the national trend is used.) The weight placed on the national trend is equal to the ACO's share of the beneficiaries in the market, and the remaining weight will be the weight for the regional trend. This has the effect of reducing the weight of the local trend in markets where the local trend is dominated by the ACO itself.

Comment

As we have discussed in our June 2018 report, basing benchmarks purely on historical spending is not sustainable. Blending of ACO-specific historical benchmarks and regional FFS benchmarks is a reasonable approach.¹¹ Because, there is no *a priori* perfect weighting of ACO historical spending and trends and regional spending and trends to achieve a benchmark, the method proposed by CMS is reasonable. However, to limit the risk of high-cost ACOs dropping out of the program, the share of the benchmark attributed to regional costs should start out low and be refined as the results of MSSP are evaluated over time.

In contrast to the use of benchmarks to calculate the distribution of “shared savings” to individual ACOs, evaluations of the MSSP program as a whole should be made relative to a counterfactual, which is the best estimate of what spending on attributed beneficiaries would have been if the MSSP program did not exist. ACO benchmarks, which are designed to create prospective incentives for individual ACOs to reduce spending and improve quality, will differ from retrospectively determined counterfactuals. However, the design of the benchmarks and ongoing evolution of the program should be informed by analyses using counterfactuals to ensure that the benchmarks both create effective incentives for the ACOs and result in savings for the Medicare program. The Commission plans to expand its analyses of ACO performance relative to counterfactuals over the next analytic year.

Proposed change: Adjust performance year benchmarks by as much as 3 percent to reflect the change in health status of all assigned ACO beneficiaries

To account for changes in the health status and demographics of an ACO's beneficiary population while mitigating concerns about increased diagnostic coding efforts, the MSSP currently risk-adjusts benchmarks differently for newly assigned ACO beneficiaries and continuously enrolled ACO beneficiaries. For newly assigned beneficiaries (those who were not assigned in the year preceding the current performance year), CMS adjusts benchmarks to reflect differences between the newly assigned beneficiaries' and the baseline beneficiary population's Hierarchical Condition

¹¹ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Categories (HCC) risk scores—reflecting both health status and demographic factors (e.g., age, sex). In contrast, for continuously enrolled beneficiaries, CMS only uses HCC scores to decrease benchmarks when the ACO enrollees' reported average health status improves (i.e., lower average HCC scores). Benchmarks for continuously enrolled beneficiaries are only adjusted upward for changes in demographic factors, not for increases in their risk scores. ACO leaders we have spoken to believe it is not equitable for benchmarks to be lowered when HCC scores decline, given that benchmarks are not raised when HCC scores increase.

CMS proposes to address these concerns by using all ACO beneficiaries' HCC scores to risk-adjust benchmarks. The average change in HCC scores would be capped at ± 3 percent between the last baseline year and any performance year. CMS believes this approach could reduce the incentive to avoid beneficiaries with complex health care needs and provide more incentive to assume performance-based risk. CMS analyses suggest the proposal would have resulted in higher benchmarks for most ACOs compared with current policy.

Comment

CMS's proposal to use the HCC scores of an ACO's entire population to risk-adjust benchmarks allows for misaligned incentives. The proposal would allow ACO benchmarks to increase due to either more aggressive coding efforts or worsening health status of ACO beneficiaries. Conversely, ACOs would potentially be penalized when patients' health is maintained or better managed—key objectives of the ACO program. CMS's observation that ACOs have modestly increased coding efforts—even under the limited incentives to do so under current policy—suggests that some ACOs may intensify those efforts given the potential 3 percent increase in benchmark in the proposal.

To improve the incentives in the MSSP, we suggest that CMS neither increase nor decrease benchmarks based on continuously enrolled beneficiaries' HCC scores in a performance year. In tandem with prospective beneficiary assignment, CMS should adjust benchmarks based on the demographic factors of continuously enrolled beneficiaries and the HCC scores of newly assigned beneficiaries. That is, it should continue current policy except it should no longer adjust benchmarks downwards if the HCC scores of continuously enrolled beneficiaries decrease. These policies would improve the alignment of ACO financial incentives with beneficiary health status, allowing ACOs to benefit financially when they do a good job of maintaining patients' health.

Proposed change: Beneficiary can opt into an ACO

Traditionally, CMS has assigned patients to an MSSP ACO based on the plurality of patient visits to physicians. Assignment is claims-based. Starting in 2018, beneficiaries could designate a primary care clinician. If that clinician was a participant in an ACO, the beneficiary would be assigned to that ACO regardless of claims history. The rule proposes an additional method of assignment in which a beneficiary would actively select (opt in) to an ACO (rather than selecting an individual physician).

Opting-in would be similar to enrolling in an MA plan. Beneficiaries would have an annual window to opt-in or withdraw their opt-in. The rule also discusses requiring that the beneficiary opting in also have at least one visit with a primary care physician in the ACO. In addition, the rule discusses a hybrid approach where a beneficiary can be aligned by naming their primary care physician or opting into an ACO, or by claims if the beneficiary had “at least seven primary care services from the ACO.”

The rule notes that setting benchmarks would be more complicated because beneficiaries who opt in would differ from other beneficiaries. In particular, they would have to still be alive at the start of the performance period, meaning their historic costs would not have any end-of-life care. Therefore, their growth in spending would have to be benchmarked against similar beneficiaries. The rule also notes that they would need a special risk-adjustment process under the hybrid system for expected costs of those who have received seven primary care services.

Comment

We believe that the predominant share of beneficiaries will continue to be assigned via claims rather than the beneficiary voluntarily identifying a primary care physician or opting into an ACO. In general, voluntary alignment is a reasonable (though rarely used) option, and we support the concept of voluntary alignment.¹² However, the Commission does not support allowing beneficiaries to opt into ACOs.

The benefit of an opt-in would be very small because it is extremely unlikely that many beneficiaries who were not already assigned through claims or by designating a primary care provider would choose to opt into an ACO. The potential negative effects could be high. For example:

- Every year we conduct focus groups with Medicare beneficiaries and ask them a series of questions to assess their knowledge and understanding of ACOs. We have found that almost no beneficiaries are familiar with ACOs. Any policy that allows beneficiaries to opt in would require a great deal of beneficiary education and generate a large amount of beneficiary unease.
- One of the primary advantages of ACOs over MA plans is their lower administrative costs. Once an opt-in arrangement is started, ACO administrative costs would increase as would CMS administrative and program integrity costs. CMS has stated it would have to monitor marketing to make sure the plans are not specifically marketing to those with low expected healthcare costs.

¹² In 2018 4,314 beneficiaries went to the CMS website and designated an ACO clinician as their primary care provider. Of those, only 339 would **not** have been assigned to the same ACO using claims. This is a very small share of the over 10 million beneficiaries assigned to ACOs. The rule proposes that once a primary care physician is selected, that selection will remain until the beneficiary returns to the website and selects another primary care physician. This could be modified to return to claims-based assignment if the beneficiary had no visits with their designated clinician within some number of years.

- Setting benchmarks would become more complicated due to opt-in patients potentially having different expected cost growth than the average beneficiary.

Given these problems with opt-in and its limited benefit (if any), we do not support adding beneficiary opt-in as an option for ACOs. CMS should continue with its policy of ensuring that ACO alignment does not reduce in any way the value of the Medicare benefit to beneficiaries. Once that is ensured, beneficiaries can continue to be assigned via claims and voluntary alignment with their primary care physician.

Conclusion

MedPAC appreciates the opportunity to comment on the important policy proposals from CMS. We also value 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 our comments, please feel free to contact James E. Mathews, MedPAC's Executive Director, at (202) 220-3700.

Sincerely,

A handwritten signature in black ink that reads "Francis J. Crosson M.D." in a cursive script.

Francis J. Crosson, M.D.
Chairman