



Medicare Payment
Advisory Commission

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Chiquita Brooks-LaSure, MPP
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

RE: File code CMS-1770-P

Dear Ms. Brooks-LaSure:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled: "Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts" published in the *Federal Register*, vol. 87, no. 145, pages 45860 to 46843 (July 29, 2022). We appreciate your staff's ongoing efforts to administer and improve Medicare's payment systems for physician and other health professional services (including implementing the Quality Payment Program and Medicare Shared Savings Program), particularly given the many competing demands on the agency's staff. We hope that our comments are helpful in those endeavors.

Our comments address the following provisions in the proposed rule:

- **Telehealth services:** The Commission supports CMS covering certain telehealth services on a temporary basis after the coronavirus public health emergency (PHE) has ended to enable the agency to gather more evidence on these services and then determine whether they should be added permanently to the Medicare telehealth services list. We support CMS requiring clinicians to use a claims modifier to identify all audio-only telehealth services. We also support CMS's proposal to return to paying the physician fee schedule's (PFS's) facility rate for telehealth services 152 days after the PHE ends.
- **Chronic pain management and treatment:** We question the necessity of creating these codes, since clinicians may bill for these services using more generic billing codes that are already available.

- **“Incident to” billing for behavioral health services:** The Commission has two concerns about CMS’s proposed change to the “incident to” billing policy for behavioral health care services: (1) the lack of transparency around “incident to” services and (2) the absence of a clear definition of “behavioral health services.”
- **Nursing facility evaluation and management (E&M) visits:** We share CMS’s concerns about the work relative value units (RVUs) proposed by the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) for nursing facility E&M visits and suggest that the RUC address these concerns by revising the RVUs or that CMS develop its own RVUs for these services.
- **Prolonged E&M visits in non-office/outpatient settings:** We agree with CMS that the prolonged services codes proposed by the AMA would result in duplicative payment and would overvalue prolonged services in non-office/outpatient settings; we therefore support the alternative codes proposed by CMS.
- **Rebasing and revising the Medicare Economic Index (MEI):** We support CMS’s proposal to rebase the MEI for 2023 using data on physicians’ expenses from 2017 and other data sources. In the long term, CMS should strive to identify or develop a single data source that has more comprehensive and detailed information about physicians’ costs than the data that CMS proposes to use to rebase the MEI for 2023.
- **Manufacturer refunds for certain discarded Part B drugs:** We support CMS’s proposal to require reporting of the JZ modifier to improve the completeness of data on discarded drugs and the accuracy of refund amounts. We also suggest that CMS reconsider its proposal to apply the refund policy only to drugs with billing codes for which all assigned NDCs are for single-dose containers or single-use packages.
- **Medicare Shared Savings Program:** We support CMS’s efforts to improve incentives for participation of providers that disproportionately serve vulnerable and medically complex populations—including targeted investment payments, adding an ACO’s prior savings to its benchmarks, transitioning to more predictable benchmark updates, and allowing for full changes in ACOs’ demographic risk scores. However, we strongly urge CMS to phase out or eliminate subsidies that do not improve the delivery of care for beneficiaries and do not protect the Trust Fund—including the regional adjustment to benchmarks and the overall increase to benchmarks due to coding intensity.
- **Quality Payment Program—qualifying alternative payment model participant (QP) determinations:** We do not support the proposal to no longer make QP determinations at the APM entity level.

Telehealth services

Under the PFS, Medicare covered a limited set of telehealth services in rural locations before the PHE. During the PHE, CMS has expanded Medicare’s coverage of telehealth services (expanding

the services that can be provided via telehealth and allowing telehealth services to be provided in urban areas) on a temporary basis. CMS proposes in this rulemaking to extend the timeframe for covering some telehealth services after the PHE ends, require a claims modifier for audio-only services, and return to paying the physician fee schedule facility rate for all telehealth services after the PHE ends.

Extend the timeframe for covering some telehealth services

Prior to the PHE, CMS established a regulatory process and criteria to review whether a telehealth service should be added to or deleted from the Medicare list of allowable telehealth services. The criteria include whether the service is similar to an existing telehealth service in authorizing legislation or whether it demonstrates clinical benefit. In response to the COVID-19 pandemic, CMS created a third category of services that are added to the Medicare telehealth services list on a temporary basis through the end of CY 2023. This new category, known as Category 3, includes services that likely have a clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence available to consider the services as permanent additions to the list. CMS will cover Category 3 telehealth services until the end of 2023 to allow stakeholders more time to submit information to CMS about the impact of these telehealth services on the quality of care provided to beneficiaries. CMS will then evaluate which services should be permanent additions to the Medicare telehealth services list.

CMS now proposes to add some new services to the Medicare telehealth services list on a Category 3 basis through the end of 2023. For some of these services, CMS has received information from interested parties suggesting potential clinical benefit. CMS is also implementing changes from the Consolidated Appropriations Act, 2022, that allow coverage of certain telehealth services for 151 days after the expiration of the PHE.

Comment

The Commission supports CMS covering certain telehealth services on a temporary basis after the PHE ends to enable the agency to gather more evidence on the services before determining whether they should be added permanently to the Medicare telehealth services list. CMS's proposal is consistent with the policy option outlined by the Commission in our March 2021 report to the Congress.¹ Under this policy option, Medicare would temporarily cover selected telehealth services for a limited duration after the PHE ends (e.g., one to two years) if there is potential for clinical benefit. This temporary expansion would allow policymakers to gather more evidence about the impact of telehealth outside of the PHE to inform any permanent changes. Policymakers

¹ Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

should use the principles of access, quality, and cost to evaluate individual telehealth services before permanently covering them under Medicare.

Require a claims modifier for audio-only services

Before the coronavirus PHE, CMS paid for telehealth services under the PFS only if the services were provided using an interactive telecommunications system that included two-way audio and video communication technology. During the PHE, CMS has waived this requirement for certain services because not all beneficiaries have the capability to engage in a video telehealth visit from their home. However, apart from telehealth services for mental health and substance use disorders and certain evaluation and management services, there is currently no information on Medicare claims that indicates whether a telehealth service was delivered by an audio-only interaction or an audio-video interaction. As a result, CMS and others are unable to use claims data to assess the impact of many audio-only telehealth services on access, quality, and cost.

CMS therefore proposes that, beginning January 1, 2023, a physician or other qualified health care practitioner billing for telehealth services will be required to append a claims modifier to Medicare telehealth claims if the services are furnished using audio-only technology.

Comment

We support CMS's proposal to require clinicians to use a claims modifier to identify all audio-only telehealth services. This proposal is consistent with the Commission's March 2022 recommendation that the Secretary require such a modifier.² We note that our recommendation was intended to apply whether Medicare is covering these services temporarily (as during the current PHE) or permanently.

Requiring clinicians to use a claims modifier for all audio-only telehealth services will enable CMS, the Commission, and researchers to assess the impact of such services on access, quality, and cost; to evaluate whether audio-only and audio-video interactions have similar effects on quality and cost; and to examine the characteristics of beneficiaries who use audio-only services. In addition, a claims modifier will allow CMS to monitor the use of these services and help protect Medicare and beneficiaries from unnecessary spending and potential fraud.

Return to paying the physician fee schedule facility rate for telehealth services

Prior to the PHE, CMS paid clinicians at the distant site for services provided by telehealth at the PFS's lower, facility-based payment rate instead of the higher, nonfacility (office-based) rate because the practice expenses for telehealth services are presumed to be lower than for services provided in person in a clinician's office. During the PHE, however, CMS pays the same PFS rate for a telehealth service that it would pay if the service were furnished in person (the PFS's facility-based or non-facility-based rate, depending on the clinician's location). CMS proposes that, 152

² Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

days after the PHE expires, Medicare pay for all telehealth services at the PFS facility payment rate, in accordance with previously established policy.

Comment

As discussed in our March 2021 report to the Congress, the Commission supports the application of the PFS facility payment rate for all telehealth services after the PHE ends.³ CMS should also collect data from practices and other entities on the costs they incur to provide telehealth services and should consider these reported costs in making any future changes to telehealth payment rates. We expect the practice costs associated with telehealth services to be lower than the costs to provide in-person services. Thus, if rates for telehealth services are set equal to rates for in-office services, the financial incentive to deliver telehealth services may be too large and may lead clinicians to overuse those services and favor them over comparable in-person services, even when a service is not needed or an in-person service may be more clinically appropriate.

Chronic pain management and treatment

As part of a broader effort to address opioid use disorder and promote non-opioid treatment of chronic pain, CMS proposes a new set of billing codes for monthly chronic pain management and treatment, modeled after existing principal care management codes. The new proposed codes would have RVUs equivalent to the principal care management codes but would be more prescriptive about the services that must be performed each month. Specifically, CMS proposes that the new monthly billing codes for chronic pain management would require a physician or other appropriate billing practitioner to personally provide a 30-minute face-to-face visit, diagnose chronic pain, assess and monitor pain, develop and use a care plan, manage treatment, manage medications, counsel on pain and health literacy, and coordinate care, among other activities. One code would cover the first 30 minutes per month of practitioner time spent on these activities and another code would cover each additional 15 minutes per month.

Comment

We question the necessity of these new codes. Clinicians can bill for the treatment of chronic pain using existing codes—such as codes for E&M office/outpatient visits, prolonged E&M services, and brief virtual check-ins. In cases where chronic pain is caused by some underlying chronic condition (e.g., arthritis, cancer), clinicians can also bill for chronic pain management using principal care management codes or chronic care management codes. For clinicians, these existing codes are likely to be preferable to the new proposed codes, since they are less prescriptive about what services must be performed and since many of them pay more per unit of time spent by the billing practitioner. Since adding codes increases the complexity of the fee schedule (and thus adds to clinicians' administrative burdens), the Commission believes the bar for adding new codes should be high.

³ Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

As a side note, we understand that part of CMS’s rationale for adopting new codes for chronic pain management and treatment is to develop data documenting the prevalence of chronic pain in the Medicare population. But creating a new code is no guarantee that clinicians will use that code when treating beneficiaries with chronic pain, especially if other easier-to-use codes are already available. Indeed, according to one recent study examining why clinicians do not use billing codes available for advance care planning (including in cases when the clinicians were actually providing this service), some clinicians preferred to use more generic billing codes (such as E&M visit codes) because they did not require clinicians to learn new requirements for a highly specific, sporadically used code.⁴ We therefore caution that adding new billing codes for chronic pain management and treatment to the fee schedule may not produce accurate data on the prevalence of chronic pain.

“Incident to” billing for behavioral health services

By statute, licensed professional counselors (LPCs) and licensed marriage and family therapists (LMFTs) cannot directly bill Medicare. However, under CMS’s “incident to” billing policy, Medicare pays for services performed by LPCs and LMFTs as auxiliary personnel under the direct supervision of a physician or other practitioner who can bill Medicare directly. Direct supervision requires the supervising practitioner to be present in the office suite and immediately available to furnish assistance and direction. Due to increased demand for behavioral health services and projected workforce shortages in this field, CMS proposes to allow behavioral health services to be furnished under general supervision (instead of direct supervision) when they are provided by auxiliary personnel as “incident to” services. General supervision means that the service is under the overall direction and control of the supervising practitioner, but the practitioner does not need to be present in the same office suite. This change would apply to “incident to” behavioral health services performed by LPCs and LMFTs.

Comment

We commend CMS for its efforts to address the growing demand for behavioral health care amid projected shortages in the workforce. Nevertheless, we have two main concerns about CMS's proposed change to “incident to” billing policy for behavioral health care services: (1) allowing these services to be provided under general supervision may create program integrity challenges, especially given the lack of transparency around “incident to” services and (2) the absence of a clear definition of “behavioral health services.” The goal of this policy change is to increase utilization of behavioral health services, but it will not be possible to ascertain which types of practitioners account for the growth of services because Medicare claims do not contain information on whether a service was provided “incident to” or which practitioner actually performed the service. Further, we do not know the extent to which LPCs and LMFTs are currently providing services to beneficiaries under “incident to” rules. In 2009, the OIG recommended that CMS identify “incident to” services with a modifier on the claim.⁵ At the time, CMS stated that “incident to” services were shared by physicians and staff and adding a modifier

⁴ Ladin, K., O.C. Bronzi, P.K. Gazarian, et al. 2022. Understanding the use of Medicare procedure codes for advance care planning: A national qualitative study. *Health Affairs* 41, no. 1: 112–119.

⁵ Office of Inspector General, Department of Health and Human Services. 2009. *Prevalence and qualification of non-physicians who performed Medicare physician services*. Washington, DC: OIG.

would be “operationally difficult.”⁶ However, CMS can specify the parameters under which the modifier is applicable—that is, a claims modifier could be required when behavioral health services are billed as “incident to” and it could indicate the type of personnel who performed the service (e.g., LPC, LMFT, clinical psychologist, clinical social worker). Because this proposal would relax the supervision policy for behavioral health services billed as “incident to” services, transparency is necessary to understand the impacts of this change, evaluate the quality of behavioral health care provided, monitor the use of services, and inform future improvements. Lastly, we suggest that CMS explicitly define “behavioral health services” by specifying the codes or groups of codes to which this policy would apply.

Nursing facility evaluation and management (E&M) visits

CMS proposes to redefine and revalue E&M code sets for various care settings (e.g., inpatient/observation, emergency department, nursing facility settings) to bring them in line with recent changes to the office/outpatient E&M visit code set. The revised office/outpatient E&M visit codes allow practitioners to select a visit level based on medical decision-making or time, and no longer require a clinician to perform a physical exam or take a patient history. Across care settings, the new E&M visit codes generally have higher work RVUs associated with them, which helps address the passive devaluation of these services that has occurred over time.

CMS proposes accepting the work RVUs recommended by the RUC for most E&M visit code sets. But the agency articulates a number of concerns with the values proposed for the nursing facility E&M visit code set. CMS views these RVUs as inconsistent, erroneous, and inaccurate. CMS does not agree with the RUC's argument that work RVUs for nursing facility E&M visits should be crosswalked to office/outpatient E&M visits, since the office/outpatient E&M visit code set includes a different number and stratification of visit levels than the nursing facility E&M code set. As a result, some codes that the RUC has proposed crosswalking involve different amounts of time; for example, the RUC proposed using the same work RVUs for a 60-minute office/outpatient visit and a 45-minute nursing facility visit. CMS also questions the RUC's proposal to assign different work RVUs to codes within the nursing facility E&M code set that take the same amount of time to deliver and the same level of decision-making (an initial and a subsequent E&M visit involving a high level of decision-making). Still, despite these concerns, CMS proposes to adopt the values recommended by the RUC in order to maintain continuity in the overall E&M code set.

Comment

Given the stated concerns with the validity of the work RVUs recommended by the RUC for the nursing facility E&M visit code set, we do not support CMS's proposal to adopt these values. CMS states that nursing facility E&M visit codes are used as reference codes for valuing many other services in the fee schedule; assigning inaccurate work RVUs to these E&M codes could therefore lead to inaccurate payments not just for these services, but also for a variety of other services that are valued in relation to these visits. We suggest that CMS ask the RUC to revisit its valuation of the nursing facility E&M visit codes; alternatively, CMS could propose its own work

⁶ Office of Inspector General, Department of Health and Human Services. 2009. *Prevalence and qualification of non-physicians who performed Medicare physician services*. Appendix F. Washington, DC: OIG.

RVUs in next year's proposed rule. In the interim, CMS should retain the current RVUs for nursing facility E&M visit codes.

Prolonged E&M visits in non-office/outpatient settings

Rather than using the prolonged services code recently adopted by the AMA's Current Procedural Terminology Editorial Panel (CPT) for the inpatient/observation E&M visit code set, CMS proposes its own codes for such services, as well as for prolonged services in the nursing facility code set and the home/residence code set; these codes would be add-on codes to the highest-level E&M visits in these code sets.

CMS's proposed add-on codes could only be billed for time beginning 15 minutes after the minimum time associated with a given service, since these visits' code descriptions refer to them taking "at least" a certain number of minutes to perform. Once this minimum amount of time plus 15 minutes has elapsed, prolonged services codes could be billed for additional service time in 15-minute increments. For example, if an E&M visit is supposed to take "at least" 50 minutes, the code for that visit covers the first 65 minutes spent on that service; the prolonged services code could not be billed for this visit until 80 minutes of total time had elapsed.

CMS proposes its own codes for these services because the agency believes the prolonged services code proposed by the CPT would result in double-payment. The CPT's prolonged services code could be billed as soon as the minimum amount of time associated with a visit had elapsed. In the example above, this would result in clinicians only needing to spend 50 minutes on a visit before becoming eligible to use the prolonged services code for any additional time. The prolonged services code could thus be billed once 65 minutes of total time had elapsed, resulting in both the base visit code and the prolonged services code covering the costs of time spent from the 50-minute mark to the 65-minute mark.

CMS also proposes different work RVUs than the RUC proposed for the CPT prolonged services code. The RUC proposed assigning more work RVUs to a prolonged service delivered in an inpatient setting compared to an office setting, arguing that services provided in an inpatient setting are inherently more intense or complex. CMS does not agree and instead proposes work RVUs for prolonged E&M visits that are the same in inpatient/observation settings, skilled nursing facilities, home/residence settings, and office/outpatient settings.

CMS proposes deactivating older codes for prolonged services that covered longer periods of time (1 hour; and each additional 30 minutes). CMS had concerns with these older codes and had stopped paying for them in CY 2021. One of CMS's concerns was that the CPT's code descriptions specified that prolonged services codes were billable after only the mid-point of their described time had elapsed (e.g., 35 minutes of prolonged services could be billed using the 1-hour prolonged services code).

Comment

We commend CMS for critically assessing the CPT codes and work RVUs recommended by the AMA for prolonged services in various non-office/outpatient settings. Given CMS's concerns with

the AMA's recommendation, we agree with CMS's proposal to use its own codes and work RVUs for prolonged services. CMS's proposed codes for prolonged services will prevent the Medicare program from making duplicative payments, and CMS's proposed work RVUs would ensure that prolonged E&M services are valued the same regardless of care setting.

Rebasing and revising the Medicare Economic Index (MEI)

CMS proposes to rebase and revise the MEI, which is an input price index that measures the average annual price change in the market basket of inputs used by clinicians to provide services and is adjusted for economy-wide productivity.⁷ The MEI consists of two broad categories: (1) physicians' own time (compensation), and (2) physicians' practice expenses (e.g., compensation for nonphysician staff, rent, equipment, and professional liability insurance). The index's cost categories (e.g., physician compensation, medical equipment) and cost weights (each category's share of total costs) are based on data from 2006 from the Physician Practice Information Survey (PPIS), which was conducted by the American Medical Association (AMA).

Before 2015, CMS used the MEI as part of the Sustainable Growth Rate (SGR) system to update clinicians' payment rates under the physician fee schedule. The Medicare Access and CHIP Reauthorization Act of 2015 repealed the SGR and established a schedule of annual updates to the physician fee schedule's conversion factor. Since 2015, CMS no longer uses the MEI to calculate updates to the conversion factor. However, CMS continues to use the MEI to update the telehealth originating site facility fee, the rural health clinic payment limits, and the annual update to the non-drug portion of the Opioid Treatment Program payment.

In addition, CMS has historically used the MEI cost weights to update the cost weights for the four components of the practice expense geographic practice cost index (GPCI): employee compensation; office rent; purchased services; and medical equipment, supplies, and other expenses. CMS has also used the MEI to recalibrate the distribution of total relative value units (RVUs) among the three components of the physician fee schedule (work, practice expense, and professional liability insurance (PLI)) so that they match the cost weights in the MEI. For example, if the MEI's cost weight for practice expense increased from 49 percent to 53 percent, CMS increased the practice expense share of total RVUs from 49 percent to 53 percent.

CMS proposes to rebase the MEI for 2023 using expense data on physician offices from the Census Bureau's Services Annual Survey (SAS) from 2017. CMS believes that the SAS is the most appropriate data source to rebase the MEI because of its public availability, its level of detail, and the representativeness of its sample. CMS proposes to use 2017 data from the SAS because certain expense categories are not available in the 2018 or 2019 data.

CMS uses other data sources to further disaggregate cost data from the SAS, including the Bureau of Labor Statistics (BLS) 2017 Occupational Employment and Wage Statistics, the Bureau of Economic Analysis (BEA) 2012 Benchmark Input-Output data, the 2006 PPIS, and the AMA's

⁷ Rebasing refers to moving the base year for the structure of costs of an input price index (e.g., updating the base year from 2006 to 2017), while revising relates to other changes such as using different data sources, cost categories, or price proxies in the price index.

2020 Physician Practice Benchmark Survey. For example, to determine the cost weight for physician compensation, CMS splits total compensation expenses from the SAS between physician compensation and compensation for all other workers in physician offices by determining the ratio of mean hourly physician wage costs to mean hourly wage costs for all occupations in physician practices. CMS uses data on mean hourly wages for each occupation from the BLS 2017 Occupational Employment and Wage Statistics and multiplies the mean hourly wage for each occupation by the number of employees in the occupation.

Moving from the current MEI, which is based on 2006 data, to the proposed rebased MEI, which is based on 2017 data, would result in an increase in the projected MEI for 2023 from 3.7 percent to 3.8 percent. The proposed revisions would also result in the cost weight for physician compensation declining from 50.9 percent to 47.3 percent, the cost weight for practice expenses increasing from 44.8 percent to 51.3 percent, and the cost weight for PLI decreasing from 4.3 percent to 1.4 percent. If CMS were to use the new MEI cost weights to recalibrate the distribution of aggregate RVUs among physician work, practice expense, and PLI for 2023, the amount of total practice expense RVUs would grow and total PLI RVUs would decline. Total work RVUs would stay constant and CMS would reduce the physician fee schedule's conversion factor to ensure budget neutrality. As a result, specialties that provide services with relatively higher practice expense RVUs (e.g., diagnostic testing facility, radiation oncology, and dermatology) would receive higher fee schedule payments, while specialties that provide services with relatively higher work RVUs (e.g., cardiac surgery, neurosurgery, clinical psychologist, and clinical social worker), would receive lower payments.

CMS proposes to delay using the rebased MEI's cost weights to update the cost weights for the practice expense GPCI and to recalibrate the distribution of total RVUs among the three components of the physician fee schedule. The reason for the proposed delay is to give interested parties the opportunity to review and comment on the rebased MEI's cost weights and the impact of using these cost weights to update the GPCI and adjust the pools of work, practice expense, and PLI RVUs.

Comment

We support CMS's proposal to rebase the MEI using data from 2017 because the MEI is currently based on data on physicians' expenses from 2006, which raises questions about its accuracy. The Commission uses the MEI as one of several indicators to annually assess whether Medicare payments for clinician services are adequate.⁸

CMS's proposed methodology for rebasing the MEI is not transparent, and it relies on several disparate data sources because no single data source contains information at the level of detail necessary to rebase the MEI. CMS's main data source (the SAS) has high-level cost categories that must be disaggregated into smaller cost categories. CMS should more clearly explain how it uses other data sources to disaggregate cost data from the SAS into smaller categories. Clinicians and

⁸ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

other stakeholders might better understand CMS's method if the agency added tables that show each step of the process with actual numeric values.

We believe there is a problem with how CMS divides total compensation expenses from the SAS into physician compensation and compensation for other workers. This step in the process is very important because physician compensation accounts for about half of total costs in the MEI and about half of total RVUs in the physician fee schedule. To split total compensation expenses between physician compensation and compensation for other workers, CMS compares the ratio of mean hourly physician wage costs to mean hourly wage costs for all occupations in physician practices. CMS uses data on mean hourly wages for each occupation from the BLS 2017 Occupational Employment and Wage Statistics and multiplies the mean hourly wage for each occupation by the number of employees in the occupation. However, the number of hours worked by each occupation in physician offices may vary (e.g., physicians may work more hours than clerical workers), and CMS's approach does not account for this variation. In effect, CMS's method assumes that each occupation works the same number of hours.

Because the main data source that CMS proposes to use to rebase the MEI has to be supplemented with several different data sources, in the long term CMS should strive to identify or develop a single data source that has more comprehensive information about physicians' input costs, such as physician compensation and compensation for other workers. If CMS could obtain data on physician compensation and compensation for other workers in physician offices, the agency would not have to use other data sources to estimate the amount of expenses in each category. In 2011, the Commission recommended that CMS regularly collect data from a cohort of efficient practices to establish more accurate work and practice expense RVUs.⁹ As part of this data collection, CMS could gather data on physicians' practice costs and use that information to rebase the MEI. Such data would probably be more accurate, comprehensive, and detailed than the data from various surveys that CMS uses to rebase the MEI in this proposed rule.

Because it would likely take several years to collect these data, we support CMS using its proposed rebased MEI in the interim. We also support CMS's proposal to wait until 2024 to use the new MEI cost weights to update the practice expense GPCI cost share weights and to recalibrate the total pools of physician work, PE, and PLI RVUs. Doing so would enable stakeholders to review and comment on the new MEI and allow CMS to better explain its method for rebasing the MEI before the agency uses it to adjust payment rates.

Manufacturer refunds for certain discarded Part B drugs

For Part B drugs available in a single-dose container or single-use package, the Medicare program, and beneficiaries via cost sharing, pay for the full dose of product in the container or package, including any portion of the product that is discarded. For some products, particularly those where a patient's dosage is determined based on their weight or body surface area, spending on discarded

⁹ Medicare Payment Advisory Commission. 2011. Moving forward from the sustainable growth rate (SGR) system. Letter to the Congress. October 14.

drugs can be significant. CMS estimated based on available data that about \$720 million of Part B drug spending was for discarded drugs from single-dose containers or single-use packages in 2020.

In the proposed rule, CMS proposes how the agency will implement Section 90004 of the Infrastructure Investment and Jobs Act, which requires drug manufacturers to provide a refund to CMS for certain discarded amounts of Part B drugs from a refundable single-dose container or single-use package. By statute, the refund amount for a single-dose container or single-use package drug is equal to the amount by which allowed charges for a discarded drug in a quarter exceed 10 percent of total charges for that drug in that quarter. For drugs with unique circumstances, the Secretary has discretion to set a percentage threshold higher than 10 percent through notice and comment rulemaking. The statute excludes certain products from the refund policy including radiopharmaceuticals, imaging agents, drugs that require filtration during the drug preparation process, and new drugs for their first 18 months on the market.

In the proposed rule, CMS proposes how the agency will determine the amount of discarded drugs for purposes of calculating the refund amount. Currently, providers are required to report the JW modifier on claims to indicate the amount of discarded drug from single-dose containers or single-use packages. However, CMS states that the agency is aware that the JW modifier is often omitted on claims, and that it is unclear whether the absence of the JW modifier on a claim indicates that there were no discarded amounts or that the modifier was incorrectly omitted from the claim. Because JW modifier data are incomplete and because refund amounts would rely on these data, CMS proposes a requirement for the use of a second modifier. Beginning January 2023, CMS proposes to require that providers use the JZ modifier in situations where there is no discarded product from a single-dose container or single-use package. Thus, under the proposal, all claims for single-dose container or single-use package drugs would be required to include a modifier, either the JW modifier to indicate the discarded amounts or the JZ modifier to attest that there were no discarded amounts.

CMS also proposes that, for a drug to be considered eligible for a refund (i.e., meet the definition of “refundable single-dose container or single-use package drug”), all NDCs assigned to that drug’s billing code must be single-dose containers or single-use packages (not multiple-use containers). Different from single-dose containers or single-use packages, Medicare does not pay for discarded drugs from multi-dose containers.

Comment

The Commission supports CMS’s proposal to require the use of the JZ modifier to improve the completeness and accuracy of data on discarded drugs. Work by the National Academies of Sciences, Engineering, and Medicine provides evidence that current reporting of the JW modifier is incomplete. For example, their analysis of Medicare claims data for the top five drugs with the most JW modifier spending found that some providers did not report the JW modifier for any patients. In addition, among those providers that did report the JW modifier, some reported it inconsistently across claims for the same patient and product. Based on these and other analyses, the report concluded that “not all health care providers use the JW modifier, and among those health care providers that use the modifier, the JW modifier is not reported consistently, even though it has been required by the Centers for Medicare & Medicaid Services since January

2017.”¹⁰ Incomplete reporting of the JW modifier means that the current claims data understate the amount of discarded drugs, and would understate refund amounts.

CMS’s proposal to require providers to report the JZ modifier would be expected to lead to more accurate data on the volume of discarded drugs, more accurate manufacturer refund amounts, and greater savings for the Medicare program. Requiring providers to report either the JZ modifier (if no discarded drug) or JW modifier (if some discarded drug) for single-dose containers and single-use packages should raise providers’ awareness of the discarded drug reporting requirement and lead to more complete reporting. It would also give CMS the ability to identify those providers who are not reporting and take steps to address reporting compliance.

We also suggest that CMS reconsider its proposal that would limit the definition of “refundable single-dose container or single-use package drug” to drugs with billing codes for which all assigned NDCs are for single-dose containers or single-use packages. The proposed definition appears to exclude from the refund policy any drugs that are sold in both single-dose containers and multiple-dose containers, even if the manufacturer predominantly sells single-dose containers and sells very few multiple-dose containers. Rather than exclude such drugs from the refund policy, CMS could apply the refund policy to the single-dose container and single-use package NDCs that are billed within such billing codes. Although providers do not bill Part B drugs at the NDC level, CMS would be able to identify the amount of drug discarded for single-dose container and single-use package NDCs through the JW modifier. To determine the refund amount threshold, CMS could use 10 percent of total charges for the billing code (including all utilization regardless of whether single-dose or multiple-dose NDCs) or 10 percent of total charges for single-use container NDCs in the billing code (based on the presence of JW or JZ modifiers). This approach would ensure that drugs predominantly, but not exclusively, sold in single-dose containers or single-use packages are subject to the refund policy.

Medicare Shared Savings Program

Shared savings and losses for accountable care organizations (ACOs) in the Medicare Shared Savings Program (MSSP) are determined by comparing per capita Part A and Part B expenditures of beneficiaries assigned to an ACO with the ACO’s financial benchmark. CMS estimates a benchmark for each ACO in each agreement period, which are five years in length as of July 2019 (the initial period of MSSP Pathways). Benchmarks use the three years prior to an ACO’s agreement period as the baseline years. CMS computes the Part A and Part B expenditures for the beneficiaries who would have been assigned to the ACO during the baseline years. For ACOs that either started a second agreement period as of 2017 or started an agreement period as of July 2019, baseline expenditures are a blend of the ACO’s historical spending and all the fee-for-service spending in an ACO’s region (including spending attributable to the ACO’s assigned population).

¹⁰ National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Implications of Discarded Weight-Based Drugs. 2021. *Medications in single-dose vials: Implications of discarded drugs*. Washington, DC: National Academies Press.
<https://www.ncbi.nlm.nih.gov/books/NBK569397/>.

The effect of regional spending (i.e., the regional adjustment) on the baseline calculation is capped at (plus or minus) 5 percent of national per capita expenditures.

Participation in the Medicare MSSP has plateaued at 10 to 11 million assigned beneficiaries since 2018, and CMS has found evidence of selective provider participation in recent years. In 2020, the majority of ACOs had a positive regional adjustment—that is, 87 percent of participating ACOs had their benchmark increased because the ACO's historical baseline spending was lower than average spending in their region. This percentage increased to over 95 percent among ACOs in two-sided risk. Selective participation and possibly other factors (such as enhanced coding efforts) has translated into substantial growth in earned shared savings payments by CMS. In 2020, CMS paid approximately \$215 per beneficiary in earned shared savings compared to around \$90 per beneficiary each year between 2015 and 2018.¹¹

As CMS noted, this selection is problematic because the Trust Fund is subsidizing participation from ACOs with already low spending compared to the region and higher spending providers with more potential for savings are choosing not to participate. CMS proposes substantive changes to the MSSP to address this concern and support the agency's goal that 100 percent of traditional Medicare beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030. CMS proposes a variety of program updates that are favorable financially to nearly all ACOs with the goal of adding participation and encouraging expansion into underserved communities.

Comment

The Commission commends CMS's efforts to encourage participation in MSSP by those with the greatest potential to improve care and generate savings. The Commission strongly supports alternative payment models and believes that giving clinicians incentives to lower the total cost of patients' care while preserving or improving the quality of care is a strategy that holds great promise.

However, we believe that achieving net program savings requires CMS to be more targeted in its MSSP policy approach. This requires not only improving incentives to encourage participation but also mitigating subsidies for selection and coding (i.e., the subsidization of already efficient providers and fueling the growth of management companies and consultants to identify favorable financial arrangements). The Commission emphasizes the importance of establishing long-run policies that encourage improved quality, savings, efficiency, and ease of implementation balanced with sufficient safeguards to ensure prudent use of Trust Fund dollars and realistic expectations of the potential for a voluntary program to continually generate savings.

Below, we discuss the following comments:

¹¹ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022. *Shared savings program fast facts – As of January 1, 2022*. Baltimore, MD, CMS. <https://www.cms.gov/files/document/2022-shared-savings-program-fast-facts.pdf>.

- The **advance investment payments (AIP) to increase participation of underserved communities** should require recipients of AIP funds to participate in two MSSP agreement periods.
- Enable **ACOs to participate in the one-sided model for a full 5-year agreement period** if the eligibility criteria targets ACOs that do NOT have a positive regional adjustment.
- Consider a benchmark **adjustment for prior savings in place of the regional adjustment** rather than continuing to allow ACOs to benefit from the pervasive selection incentivized through the positive regional adjustment.
- Support adding **prospective, external factor in growth rates to the benchmark** with careful consideration of how the growth rate is calculated and how it interacts with current policies.
- **Transitioning to a full administrative benchmark** could set MSSP on a better long-term path if the agency applies the correct parameters.
- Support **aligning the assignment window for ACOs selecting prospective assignment**.
- **Changes to the methodology for addressing growth in risk scores** should allow for the full demographic risk score increase, but absent any underlying efforts to address ACO's coding efforts, CMS should offset any further risk score increases with a uniform coding adjustment across all ACOs that corrects for overall MSSP HCC risk score increases. On average, patients treated by ACO physicians should not have more rapidly declining health than patients treated by other physicians.
- ACOs should meet the **Minimum Savings Rate to share in savings**, even if the ACO is low revenue and meets quality performance standards.
- Support **adding a health equity quality adjustment in the quality score** and encourage CMS to work toward reporting of measure results stratified by sub-populations to further address health care disparities and advance health equity.

Advance investment payments (AIP) to increase participation of underserved communities

In this proposed rule, CMS proposes to provide up-front payments to all eligible inexperienced ACOs¹² and an additional two years of ongoing quarterly payments to these ACOs to encourage providers caring for underserved beneficiaries to join the MSSP. The AIP would contribute to start-up funds needed to form and sustain an ACO. The size of quarterly payments would increase if the ACO serves more beneficiaries who are dually eligible for Medicaid or live in an area with a

¹² Eligible AIP ACOs would be those that: are inexperienced with performance-based risk Medicare ACO initiatives, are low revenue, include only small hospitals or CAHs, are not owned by a health plan, and are eligible for the BASIC track of MSSP.

higher Area Deprivation Index (ADI) ranking. Below we provide comment on evaluating and monitoring of the AIP, AIP recoupment requirements, basing the up-front payment on meeting a minimum risk factors–based score, tying payments to quality of care, and using LIS instead of dual eligibility in the risk factors–based score.

Need for ongoing evaluation and monitoring of the AIP

The CMS Innovation Center (CMMI) previously tested two advance payment models—the Advance Payment Model that ended in 2015 and the ACO Investment Model (AIM) that ended in 2018. The prior models were designed to encourage formation of smaller ACOs in underserved areas. AIM explicitly targeted formation of ACOs in rural areas and was found to save \$381.5 million over three years, or 2 to 3 percent of total Medicare spending per year for assigned beneficiaries in the model.¹³ However, the Advance Payment Model was found to increase spending over the 3-year model (by \$70 million in the third year).¹⁴

Comment

We caution CMS against concluding that the impacts of the AIP will be the same as those found in AIM without ongoing examination. First, the two prior Advance Payment Model evaluations yielded conflicting results on Medicare spending, and the more recent AIM Test 1 Model was targeted specifically towards ACOs located in rural areas. Rural location is not a criterion for AIP participation, nor was it for the Advance Payment Model. Moreover, neither the Advance Payment Model nor AIM had made advance payments contingent on caring for undeserved beneficiaries or beneficiaries residing in underserved areas. While we support the AIP and approach of basing payments on caring for underserved beneficiaries, we urge CMS to continue to monitor and evaluate the impact of providing these funds on program spending and quality of care.

AIP recoupment requirements

Consistent with AIM and the Advance Payment Model, ACOs in the proposed AIP that complete their first (5-year) agreement period need not pay back any unrecouped AIP payments if they choose not to enter a second agreement period.¹⁵

Comment

The Commission believes that the MSSP should be designed to achieve savings for the Medicare program. Doing so requires balancing incentives that both encourage participation and generate savings. Advance incentive payments can support participation but may adversely affect the ability of the MSSP to achieve savings for Medicare, particularly if organizations exit the program before

¹³ Abt Associates. 2020. *Evaluation of the Accountable Care Organization Investment Model: Final report*. Prepared for the Centers for Medicare & Medicaid Services by Abt Associates. Rockville, MD: Abt Associates. <https://innovation.cms.gov/data-and-reports/2020/aim-final-annrpt>.

¹⁴ L&M Policy Research. 2016. *Evaluation of CMMI accountable care organization initiatives: Advance payment ACO final report*. Prepared for the Centers for Medicare & Medicaid Services by L&M Policy Research. Washington, DC: L&M Policy Research. <https://innovation.cms.gov/files/reports/advpayaco-fnevalrpt.pdf>.

¹⁵ If the ACO later returns to the MSSP, CMS will recoup any remaining AIP funds from future earned shared savings.

repaying the advance payments. This is a particular concern because most AIM ACOs (over 70 percent) chose to exit the MSSP at the end of the agreement period.¹⁶ As of 2018, only about half¹⁷ of AIM funds were recouped by CMS, with 19 of the 41 AIM Test 1 ACOs not earning any shared savings from which to recoup payments. Thirteen of the 19 ACOs ultimately exited the program. The AIM evaluation found that many AIM ACOs exited because of the prospect of taking on two-sided risk in the next agreement period (the end of AIM corresponded with the start of Pathways to Success, under which ACOs must eventually take on two-sided risk). The Commission is concerned that significant, forgivable upfront payments coupled with ACOs exiting the program will preclude program savings. We believe this will require continued monitoring from CMS. If exit remains high and significant upfront payments are not recouped, several types of corrective action may be needed. This could involve lowering upfront payments or requiring repayment upon exit of the program. Based on findings from prior advance payment models, the Commission contends more stringent requirements may be needed in the future to deter ACOs from receiving advance payments and exiting the MSSP before they are paid back.

Risk factors–based AIP payment amounts

As with both the Advance Payment Model and AIM, CMS proposes that AIP consist of an up-front \$250,000 and 8 quarterly payments based on the number of assigned beneficiaries, capped at 10,000. In AIP, CMS proposes that the quarterly payments would range from \$0 to \$45 per beneficiary based on a risk factors–based score that is between 1 and 100, with higher scores translating to greater per beneficiary dollars. Dual-eligible beneficiaries would be assigned a score of 100 and non-dual-eligible beneficiaries would be assigned a score corresponding with the ADI ranking of the location in which the beneficiary resides. AIP ACOs would receive the maximum per beneficiary amount for beneficiaries with scores between 85 and 100 and no per beneficiary payments for beneficiaries with scores between 1 and 24. Total quarterly AIP payments would be the sum of the payments across beneficiaries. Per beneficiary payments are capped at a maximum of 10,000 beneficiaries, and CMS is soliciting comment on the one-time fixed payment and using the highest scoring 10,000 beneficiaries to determine the quarterly payment or an alternative, such as the average risk factors–based score of all the ACO’s assigned beneficiaries.

Comment

The Commission supports using an average risk factors–based score for all of the ACO’s assigned beneficiaries, rather than the highest 10,000 risk factors–based score for ACOs with greater than 10,000 assigned beneficiaries. We believe this best aligns with the goal of targeting AIP funds to underserved beneficiaries. Using an average score, rather than the highest 10,000 would encourage large ACOs to continue to include beneficiaries with high risk factors–based scores, beyond the first 10,000, inducing greater inclusion of underserved beneficiaries. Further, we support making the up-front \$250,000 contingent upon reaching a minimum average risk factors–based score (such as 25). That is, ACOs with a risk factors–based score of less than 25 across all its assigned

¹⁶ Abt Associates. 2020. *Evaluation of the Accountable Care Organization Investment Model: Final report*. Prepared for the Centers for Medicare & Medicaid Services by Abt Associates. Rockville, MD: Abt Associates. <https://innovation.cms.gov/data-and-reports/2020/aim-final-annrpt>.

¹⁷ Using the most recent 2019 and 2020 results, approximately 60 percent of AIM Test 1 funds were recouped.

beneficiaries would not be able to participate in AIP (since it would receive no up-front or quarterly payments).

The Commission also notes that while the AIP will target funds to underserved communities and incentivize ACOs to care for underserved beneficiaries, there is no explicit requirement that receipt of those funds is contingent on ACOs providing any standard of quality care to underserved beneficiaries. At the very least, we encourage CMS to actively and continually monitor outcomes stratified by subgroups to ensure the provision of high-quality care to underserved beneficiaries.

Using LIS instead of dual eligibility in the risk factors–based score

CMS is soliciting comment on the use of beneficiaries’ dual-eligibility status to identify underserved beneficiaries, or an alternative such as the Part D low-income subsidy (LIS).

Comment

Historically, the Commission has used full dual eligibility as a marker for low-income populations in many of our analyses of the impacts of various Medicare policies. In our most recent work on developing policies to identify and support safety-net hospitals, we used a more expansive definition of low-income beneficiaries that included fully dually eligible beneficiaries, partially dually eligible beneficiaries, and those non–dually eligible beneficiaries who would otherwise be eligible for the LIS under Part D (collectively, we refer to this group as ‘LIS beneficiaries’). We found that using the LIS designation, rather than full or partial dual-eligibility status, helped to reduce the impact of variation in state Medicaid benefits on nationally standardized Medicare policies.¹⁸ We urge CMS to consider using LIS in the risk factors–based score, rather than dual eligibility.

ACOs eligible to participate in the one-sided model for a full 5-year agreement period

Under current policy, all ACOs must transition to some degree of two-sided risk by their third year. CMS proposes to allow new and inexperienced ACOs to remain in a one-sided risk arrangement (i.e., BASIC Level A and B) for a full 5-year agreement period. The ACO can then renew into the standard BASIC track again, which requires movement toward two-sided risk in the 3rd year. That is, eligible ACOs may have up to 7 years in one-sided risk before moving to two-sided risk. This option would be available to ACOs that are inexperienced with performance-based risk Medicare ACO initiatives¹⁹ and new to MSSP or currently in a one-sided track.

Comment

The Commission understands that allowing more time under one-sided risk can promote participation among new and inexperienced ACOs. However, allowing seven years of one-sided risk may not be needed given that most providers should already have some experience under an alternative payment model. Beginning with Medicare’s Physician Group Practice Demonstration in

¹⁸ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

¹⁹ ACOs with “experience with performance-based risk Medicare ACO initiatives” are those that have participated in two-sided risk or are composed of at least 40 percent ACO participants that have participated in two-sided risk.

2005, population-based models in Medicare will be entering their 20th year in 2025. As of January 2022, 72 percent of Medicare beneficiaries with Part A and Part B coverage were either aligned with an ACO-like entity or were enrolled in a Medicare Advantage (MA) plan or other private plan.²⁰ At least some of the remaining 28 percent of beneficiaries are treated by providers who have experience under an ACO model, advanced primary care model, episode-based model, or a value-based model under an MA plan.²¹ Seven consecutive years of one-sided risk potentially poses an unnecessary risk of allowing shared savings payments from Medicare through random variation without any assurance that the care delivered to beneficiaries fundamentally changed. Extending one-sided risk arrangements for up to seven years adds to the risks that MSSP currently poses to the Trust Fund, and this is exacerbated by selective participation to take advantage of regionally adjusted benchmarks and coding allowances of up to 3 percent above and beyond the risk score increases of the national assignable population. Overall, we are particularly concerned about the financial risks to the Medicare program created by the combination of regional benchmarks and one-sided risk. These concerns were not nearly as salient during the early years of MSSP.

Because the regional adjustment is based on the most recent baseline year of spending, an ACO could theoretically have five years of one-sided risk without any decrease to its positive regional adjustment—even if the ACO’s performance year spending is higher than its historical spending trend. If CMS believes that seven years under one-sided risk is warranted, the Commission strongly suggests that an ACO should not benefit from both additional years under one-sided risk and a positive regional adjustment to its benchmarks. That is, we suggest that, in addition to the criteria on experience and current participation status, CMS would determine if the ACO’s baseline expenditures resulted in a positive regional adjustment (using the preliminary historical benchmark report that is typically provided within three months of an ACO’s agreement start date). Those ACOs would not be eligible for an additional year in BASIC Levels A or B. This determination would align with the regional adjustment baseline expenditures calculation that occurs each year when ACOs submit an updated list of participants. The Commission believes adding this requirement would strike a balance between enabling ACOs needing more time in one-sided risk to receive that time and limiting the selection of participants with favorable spending benchmarks into risk-free arrangements.

Adjusting benchmarks to account for an ACO’s prior savings and reduce negative regional adjustments

Benchmark rebasing helps account for more recent changes in both the Medicare program and an ACO’s population. However, CMS understands that ACOs experiencing efficiency gains will likely have lower spending than they would have without ACO participation and that these efficiency gains become part of an ACO’s baseline spending when its benchmark is rebased—

²⁰ Medicare Payment Advisory Commission. 2022. *A data book: Health care spending and the Medicare program*. Washington, DC: MedPAC.

²¹ The Commission has previously found that a substantial share of beneficiaries do not continuously remain assigned to the same ACO but remain in FFS. Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

effectively “ratcheting” an ACO’s benchmark downward over time and penalizing the ACO for its own success in achieving gross savings for the Medicare program.

In addition, CMS has observed selective participation behavior, where ACOs that have already achieved efficiency or that are serving beneficiaries with lower health risks are more likely to participate. Providers with the greatest opportunity to reduce spending (those that are inefficient and high spending relative to their region and that would receive a negative regional adjustment if they formed an ACO) are far less likely to participate. ACOs with the largest negative regional adjustments also tended to be those with high risk scores (but not necessarily risk score increases) and high proportions of beneficiaries eligible for Medicaid.

CMS seeks to reverse these trends. The agency proposes to address the ratcheting of savings from benchmark rebasing by adding a prior-savings adjustment to benchmarks. To account for prior shared savings payments, the adjustment would be multiplied by 50 percent (e.g., an ACO that had a per capita average of \$100 in spending below its prior benchmarks would have \$50 added to its performance year benchmark). This adjustment would be based on the three performance years immediately preceding the start of a new agreement period. A similar method was used in 2016 but was subsequently replaced by the regional adjustment. Rather than using a prior-savings adjustment to replace the regional adjustment, CMS would use an ACO’s prior savings to increase its benchmark—except in instances where the regional adjustment resulted in a higher benchmark. CMS believes that only adjusting for prior savings when it is more advantageous for ACOs than the regional adjustment would limit the negative ratchet effects of benchmark rebasing.

CMS’s adjustment for prior savings would differ depending on whether an ACO had a negative or positive regional adjustment to its benchmarks. For ACOs with a negative regional adjustment to benchmarks, CMS proposes to lower the cap on the regional adjustment from 5 percent of national per capita fee-for-service (FFS) expenditures for assignable beneficiaries to 1.5 percent. This 1.5 percent cap will be lowered even further based on the share of Medicaid-eligible beneficiaries assigned to the ACO and the ACO’s risk score. CMS’s adjustment for prior savings would be added to the negative regional adjustment and could potentially result in a positive adjustment to these ACOs’ benchmarks.

For ACOs with a positive regional adjustment to benchmarks, CMS would keep the cap on the regional adjustment at 5 percent—creating an asymmetric cap compared with ACOs that had a negative regional adjustment. CMS’s adjustment for prior savings would be compared against an ACO’s positive regional adjustment, and the ACO’s benchmark would be increased by the higher of the two adjustments. To mitigate a benchmark “ratcheting” from ACO savings, CMS believes that positive regional adjustments should be allowed when they are larger than prior-savings adjustments.

CMS seeks comment on the prior-savings adjustment used to adjust a benchmark’s baseline expenditures and the proposal to create an asymmetric cap on the regional adjustment.

Comment

We agree with CMS’s efforts to improve incentives for ACOs that improve their efficiencies in care delivery, particularly for providers that serve beneficiaries with higher spending in their

region. As CMS notes, improving the management of care for these beneficiaries (who often have relatively complex medical needs) provides the greatest opportunity to address the care needs of the most underserved beneficiaries and achieve program savings. Specifically, we concur with CMS's proposal to calculate a prior-savings adjustment. Until CMS can fully phase in an austere fixed administrative growth rate with a regional efficiency discount in the growth rate (described later in this comment letter), a prior-savings adjustment is a reasonable policy to mitigate the ratcheting of gross savings that some ACOs have generated for the Medicare program.

Notwithstanding our support for these efforts, we strongly urge CMS to use the prior-savings adjustment as a means to phase out the regional adjustment to an ACO's benchmark baseline expenditures. In its June 2016 final rule, CMS acknowledged that keeping both a prior-savings adjustment and a regional adjustment was unnecessary because the agency anticipated a regional adjustment was a better method for leaving an ACO's savings in its benchmark. CMS is now re-introducing the prior-savings adjustment to ensure rebased benchmarks continue to serve as a reasonable baseline. However, even though the regional adjustment has coincided with an elevated level of selection and put MSSP at risk of being a net cost to the Medicare program, CMS will continue to apply a negative adjustment to ACOs that serve high-spending populations and a positive regional adjustment for certain ACOs that already have low spending in their region (i.e., ACOs that receive higher benchmarks without necessarily demonstrating efficiency gains during their MSSP participation).

We find no evidence to suggest that the regional adjustment has led to net savings for the Medicare program. Prior studies that estimated savings in MSSP examined the years prior to CMS's implementation of the regional adjustment, which included more restrictive policies on coding intensity and far lower shared savings payments per assigned beneficiary.^{22, 23} Between 2013 and 2017, shared savings payments per assigned beneficiary increased by 1 percent. In comparison, between 2017 and 2020, shared savings payments per assigned beneficiary increased by 148 percent. We find no indication that these extraordinary increases in shared savings payments were offset with gross savings. For example, CMS estimates that the current MSSP would produce a net cost to the Medicare FFS program of \$4.2 billion over the 2023–2034 period (without accounting for the ensuing increase to MA benchmarks). In addition, CMMI's AIM evaluation examined the changes in spending for 89 non-AIM MSSP ACOs in 2016 and 77 non-AIM MSSP ACOs in 2017.²⁴ CMMI found slight increases in gross spending for these MSSP ACOs relative to a comparison group of similar beneficiaries who were not assigned to an ACO. Further, while the 41 AIM Test 1 ACOs showed substantial decreases in gross spending, a follow-up analysis from the evaluation's authors found that changes in the AIM ACO's participant TINs (i.e., selection of providers) reduced these

²² Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

²³ McWilliams, J. M., L. Hatfield, B. Landon, et. al. 2018. Medicare spending after 3 years of the Medicare Shared Savings Program. *New England Journal of Medicine* 379, no. 12: 1139–1149.

²⁴ Abt Associates. 2019. *Evaluation of the Accountable Care Organization Investment Model*. Appendix 4D. Prepared for the Centers for Medicare & Medicaid Services by Abt Associates. Rockville, MD: Abt Associates. <https://innovation.cms.gov/aim-second-annrpt-app.pdf>.

savings by 41 percent in 2018.²⁵ Overall, we find that the degree of savings achieved by MSSP ACOs has not been commensurate with the substantial increase in shared savings payments to those ACOs in recent years. Taken together, the evidence suggests that benchmarks were inflated by ACOs that received a positive regional adjustment. Thus, phasing out the regional adjustment may be a way to reduce illusory savings and would not “ratchet” down real MSSP savings.

Absent a phase-out of the regional adjustment, MSSP is likely to continue experiencing selection by ACOs. As CMS described in the notice for proposed rulemaking:

“This selective participation is in response to regional benchmark adjustments that have increased shared savings payments to low spending ACOs and has resulted in higher cost beneficiaries, who have the most need for ACO care management, being increasingly excluded from assignment to ACOs participating in the program.” (page 46400) CMS also states: *Setting aside the net costs to the Trust Funds from subsidizing participation by ACOs with spending already below their region, the chief concern with this pattern of participation under the current methodology is that the providers/suppliers with the greatest savings potential (those with high spending relative to their region) have fewer incentives to participate.”* (page 46211)

While CMS has attempted to improve participation among ACOs serving high-spending populations by making the regional adjustment asymmetrical (i.e., lowering the current 5 percent cap on negative regional adjustments to 1.5 percent), CMS’s proposal would continue to penalize these populations in favor of participation from ACOs that are already low spending in their region (and receive a positive regional adjustment). Under CMS’s proposal, ACOs that receive a positive regional adjustment would still be eligible for up to a 5 percent increase in their benchmark. These ACOs would continue to receive a positive regional adjustment if it exceeds their prior-savings adjustment. In addition, a reasonable prior-savings adjustment requires a reasonable benchmark for the ACO. Under CMS’s proposal, prior savings would be based on benchmarks that were already inflated due to the regional adjustment. Thus, many ACOs would have an inflated prior-savings adjustment, potentially in perpetuity because the proposed policies still favor participation from ACOs with a positive regional adjustment.

Further, regional adjustments to benchmarks rely heavily on the accuracy of risk adjustment. It’s unclear whether risk adjustment is adequately accounting for an ACO’s regional efficiency. For example, the HCC risk-adjustment model remains susceptible to some overestimation of the costs associated with low-spending outliers and some underestimation of the costs associated with high-spending outliers.²⁶ This discrepancy in the HCC model may further penalize ACOs that disproportionately serve high-needs populations. While evidence suggests that this dynamic creates favorable risk-adjusted spending for beneficiaries switching from FFS to MA, ACOs can create this favorable bias in regional benchmarks by being particularly selective about identifying

²⁵ Trombley M. J., M. McWilliams, B. Fout, et al. 2022. ACO Investment Model produced savings, but the majority of participants exited when faced with downside risk. *Health Affairs* 41, no.1. Exhibit A14. https://www.healthaffairs.org/doi/suppl/10.1377/hlthaff.2020.01819/suppl_file/2020-01819_suppl_appendix.pdf.

²⁶ Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

physician practices that serve assignable beneficiaries with persistently low risk-adjusted spending.^{27, 28}

Given CMS's goal of having 100 percent of Medicare beneficiaries in a population-based payment arrangement, CMS could consider other incentives for participation of ACOs that are already efficient relative to their region. Such incentives could include higher shared savings rates, protection from shared losses up to an amount equivalent to the regional adjustment, and prospective trend factors that could be slightly higher relative to an ACO's regional spending. Notwithstanding CMS's participation goal, the incentives CMS considers should not compromise the Trust Fund. As we stated in our comment letter on the 2011 proposed rule for MSSP:

“Making the ACO terms generous enough to lure a large number of ACOs into the program could mean a high percentage of ACOs failing to achieve savings for Medicare and also failing to deliver their patients high quality, coordinated care. It is not in the long-term interest of the shared savings program, or of Medicare more generally, to encourage participation by organizations that are unlikely to be successful.”²⁹

Incorporating a prospective, external factor in growth rates used to update the historical benchmark

Currently, CMS trends forward baseline expenditures to an ACO's performance year by blending the actual growth rates in the ACO's regional per capita expenditures and national per capita expenditures. The weight of the national component is equivalent to the ACO's share of assignable beneficiaries in its service area. Thus, as the ACO's share of assignable beneficiaries in its region increases, CMS places a higher weight on the national component of the blend and lower weight on the regional component.

This approach to weighting the blend of national and regional growth rates was adopted, in part, to reduce the degree to which benchmarks among ACOs with high regional penetration (particularly those in rural areas) are influenced by realized spending changes among their own assigned beneficiaries and other ACOs in its region. Even with this approach, however, the method CMS uses to update ACOs' historical benchmarks may still be too heavily influenced by realized changes in the ACO's own spending, which is partially reflected in regional spending, as well the collective impact of all ACOs on national spending (even if not substantial to date).

Including realized changes in FFS spending in benchmark update calculations has led to concerns by the Commission and others that when ACOs succeed in slowing spending growth, they are penalized for doing so because benchmark updates reflect the slower growth, thus making it increasingly difficult for an ACO to continue getting spending below the benchmark and receive

²⁷ Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

²⁸ Jacobson, G., and T. Neuman. 2019. *Do people who sign up for Medicare Advantage plans have lower Medicare spending?* Washington, DC, Kaiser Family Foundation.

²⁹ Medicare Payment Advisory Commission. 2011. Comment letter on the Centers for Medicare & Medicaid Services' (CMS's) Medicare Shared Savings Program accountable care organizations proposed rule. June 6.

shared savings payments. According to CMS, this so-called “ratchet effect” on benchmarks can discourage ACOs from taking actions to reduce spending by providing care more efficiently and may dampen incentives to participate in the program.

To address concerns about the ratchet effect, CMS is proposing to make changes to the current two-way blend of national and regional growth rates. The agency is proposing a method of calculating benchmark update rates using a three-way combination of growth rates that would utilize the current national and regional weighted blend, along with a prospectively projected trend factor that is decoupled from actual spending.

The prospectively determined growth factor, referred to by CMS as the Accountable Care Prospective Trend (ACPT), would be based on the U.S. Per Capita Cost (USPCC), which encompasses total Medicare FFS spending. The ACPT would be combined with the existing national and regional blend, such that the prospective trend would account for one-third of the overall benchmark growth factor and the weighted national-regional rates would account for the other two-thirds. The existing USPCC growth projections are developed by the Office of the Actuary and are used for establishing Medicare Advantage rates. CMS is proposing to use a modified version of USPCC to make projections of per capita FFS spending expenditures for five years into the future. Basing the ACPT on these projections means that a portion of the benchmark update would reflect spending trends that are independent of savings achieved by an individual ACO, or ACOs collectively, during the five-year period.

If finalized, the agency says this approach would increase incentives for ACOs to reduce spending because there would be less risk of those reductions negatively impacting their benchmark updates. This, in turn, could lead to increases in shared savings payments to ACOs and stronger incentives to participate in the Shared Savings Program.

Comment

We agree with CMS’s efforts to address the ratchet effect on ACO benchmarks and support moving to decouple benchmark updates from realized changes in spending. In our June 2022 report, the Commission expressed concerns that by feeding realized changes in FFS spending back into benchmark updates, over time the current method used by MSSP makes it increasingly difficult for ACOs that succeed in slowing spending growth to keep spending below their benchmarks. We agree with CMS that this can have the effect of disincentivizing ACOs from providing the most efficient care possible and may discourage participation in the program.

Therefore, we are supportive of the proposal to reduce the degree to which benchmark updates are influenced by realized changes in spending among ACOs, and base part of the update factor on an administratively determined growth rate that does not include such changes.

However, we do have reservations regarding some aspects of CMS’s proposal. First, our analysis of USPCC projections indicates that these projections have typically overestimated growth in per capita spending. This is likely because estimates of growth in volume and intensity of FFS services have been too high. CMS’s own analysis also found that an ACPT projected in 2009 would have overstated per capita spending growth from 2008 to 2013 by 9 percentage points. This is

concerning because basing ACO benchmark updates on projections that tend to overestimate growth in volume and intensity could result in benchmarks that fail to adequately incentivize ACOs to provide care efficiently and lead to shared savings payments that are larger than warranted. The tendency for USPCC to overestimate growth suggests that the benchmark growth rate should be lower than the USPCC (e.g., a discount factor should be applied to this portion of the growth rate).

Another issue with basing part of the benchmark growth rate on USPCC is that the spending measure includes expenditures for several types of spending that are not under the control of ACOs and should not be included in benchmark growth rates. CMS acknowledges that the APCT needs to be based on a modified version of USPCC to remove expenditures for indirect medical education (IME) and disproportionate share (DSH) payments. We also believe that shared savings payments or other value-based performance payments made to ACOs or providers should also be excluded from the APCT. These payments result from savings already achieved in alternative payment models such as MSSP and do not represent spending on items and services that ACOs can influence. Including those payments in the benchmark growth rate would act to increase benchmarks by essentially “double counting” those savings, which would result in less pressure on ACOs to reduce spending growth. Not only would this undermine the goals of MSSP, but the higher spending in FFS would carry through to Medicare Advantage benchmarks, resulting in less pressure on private plans to bring down spending growth in that part of the Medicare program.

Further, incorporating the APCT should coincide with phasing out the regional adjustment to baseline expenditures in an ACO’s benchmark. If the intent of the APCT is to reduce ratcheting effects to benchmarks (i.e., leave an ACO’s gross savings in its benchmarks), CMS’s proposed prior-savings adjustment and its regional adjustment represent duplicative methods. In the case of the regional adjustment, it can create ratcheting for ACOs that serve high-spending populations. As we noted in our June 2022 report, a blend of regional and participant spending benefits low-spending providers, since they would have an easier time staying within such a benchmark target, given their track record of low spending. High-spending providers would have to generate more substantial reductions in spending. Thus, without a downward adjustment to the positive regional adjustments currently received by nearly 90 percent of MSSP ACOs, the APCT would serve to further subsidize these ACOs without any realized efficiency gains for the Medicare program.

Request for comment on incorporating an administrative benchmark approach into the Medicare Shared Savings Program

The proposed rule envisions changing the method used to update ACO benchmarks from a two-way blend of national and regional spending trends to a three-way blend of national and regional trends along with a prospectively projected growth rate. However, because the proposed three-way blend does not fully address concerns about the negative impact the ratchet effect can have on ACO incentives to reduce spending growth and program participation, CMS is seeking comments on transitioning to a benchmark update method that is completely decoupled from ACO performance.

Specifically, CMS is contemplating an approach that would base benchmark updates entirely on a prospectively projected ACPT as the only factor used to calculate updates to benchmarks and

phasing out the use of observed spending at the national and regional levels. CMS would continue to utilize an ACO's historical FFS risk-adjusted spending to establish the ACO's historical benchmark, with some modifications contained in the proposed rule and some additional changes contemplated in the request for comment. In subsequent years, each ACO's benchmark update would be based on the annual ACPT factor (including regional adjustments for differences in prices) that is intended to reflect what FFS spending would be in future years in the absence of ACO participation. Similar to the proposed changes in the proposed rule, the request for comment specifically suggests using a modified version of the USPCC projections developed by the Office of the Actuary. The agency suggests establishing an ACPT for five-year increments and averaging the yearly growth rates over the period so that each year's growth rate would be uniform and predictable.

The agency is considering making separate projections within the ACPT to account for growth in the volume and intensity of services, price growth, and beneficiary demographic factors. The volume and intensity portion of the ACPT would be held constant over each five-year period, but retrospective adjustments could be made to account for differences between the projected and realized price and demographic components. Retrospective changes could also be made to the ACPT to account for extreme and uncontrollable circumstances.

CMS recognizes that as ACO participation grows, and ACOs account for a larger share of overall FFS spending, it will be increasingly difficult to base the ACPT on projections of what spending would have occurred in the absence of ACO participation. As such, the agency says it may need to use "other external indices" as an alternative to USPCC growth projections in determining the benchmark update factor.

CMS also is considering applying a scaled discount factor to the ACPT within each region that accounts for differences between low spending and high spending ACOs. More efficient ACOs (i.e., those with spending below the regional average) would have smaller or no discounts applied to their ACPT, while less efficient ACOs (i.e., those with spending above the regional average) would have larger discounts applied to their ACPT. CMS says that over time, the varying regional discount factors could lead to convergence around a common, risk-adjusted benchmark within each region.

Another change being contemplated by CMS is removing the negative regional adjustment, which is currently used to decrease benchmarks for ACOs whose spending is above their region's average spending; positive regional adjustments would continue to be applied. This part of the proposal is intended to address evidence that the current two-sided regional adjustment has led to selective participation by low spending ACOs, so the change would encourage ACOs with historically high spending to participate in the program, while still rewarding ACOs with below-average historical spending.

Since benchmarks based on historical spending may reflect racial inequities and lack of support for underserved and disadvantaged communities, the agency is also seeking input on how an administrative benchmarking approach can account for disparities in care and be used to advance health equity.

Comment

The request for comment builds on the proposal to base part of benchmark updates on an administratively determined growth rate that is decoupled from ACO performance and realized changes in spending. With certain caveats explained below, we support the approach outlined in the request for comment, which largely aligns with the benchmarking approach discussed in our June 2022 report to the Congress.

As we state in that report, administratively set benchmarks that are exogenous—i.e., not impacted by ACOs' performance and their impact on spending—can help address the ratchet effect, leading to greater incentives to reducing spending and higher participation. The growth factors used to update benchmarks should grow at a fast enough rate to ensure that ACOs have a chance to earn shared savings without compromising care quality, yet slow enough that this approach generates net savings for the Medicare program relative to FFS Medicare spending that would have occurred in the absence of this approach. We also support using the administrative growth rate for five-year increments because it increases the amount of time between when historical ACO benchmarks will be rebased (or partially rebased) to reflect actual changes in spending, which is another form of ratcheting. We also support applying variable regional discount factors to encourage high spending ACOs to slow spending more quickly and move towards regional convergence of benchmarks and spending. We note that the regional discount factors should incorporate the Commission's recommendations on establishing geographic areas for payment by extending the ACO service area to a larger market area (e.g., core-based statistical areas, health service areas, or hospital referral regions).

While we generally support the approach put forward by CMS for comment, there are aspects of the proposal that we would change in order to make MSSP work efficiently for all relevant stakeholders, not only the ACO-participating clinicians and providers, but also the Medicare program writ large, and the beneficiaries and taxpayers who fund the program.

- As explained above, we have observed that the USPCC projections tend to overestimate growth in Medicare FFS spending, likely due to overestimates of growth in volume and intensity. To achieve savings, we suggest that the growth rate of the administrative benchmark may need to be set substantially below the USPCC. Setting the administrative benchmark below the USPCC would be intended to avoid subsidizing ACOs that do not produce gross savings in perpetuity.
- The methodology used to calculate USPCC includes expenditures for shared savings payments made to ACOs. Including these payments in the per capita spending measure would artificially increase benchmark growth rates and they should be excluded from the ACPT. In addition, ACO shared savings payments are included in MA benchmarks—effectively double paying for incentive payments when these payments are not offset by gross savings to the Medicare program.
- We are strongly concerned that keeping the positive regional adjustment from historical benchmark calculations will inflate an ACO's benchmark in perpetuity and continue the selection behavior that has occurred since the introduction of a regional adjustment in

2017. As we stated above, the evidence suggests that benchmarks were inflated by ACOs that received a positive regional adjustment and absent a phase-out of the regional adjustment, MSSP is likely to continue experiencing selection by ACOs.

Aligning the assignment window for ACOs selecting prospective assignment

MSSP ACOs can choose to be assigned beneficiaries via a retrospective reconciliation method (based on the plurality of primary care visits during the performance year) or via a prospective method (based on the plurality of primary care visits during the fiscal year prior to the start of the performance year). In developing an ACO's benchmark, CMS calculates spending for the beneficiaries that would have been assigned to an ACO in the three years prior to the start of the ACO's agreement period. Under current policy, the regional adjustment for all ACOs is calculated using assignable beneficiaries via a retrospective reconciliation method. Thus, when an ACO chooses prospective assignment, the assignment windows for the ACO's spending do not match the assignment window of the regional blend. CMS has found that this discrepancy results in a benchmark bias in favor of ACOs that choose prospective assignment. Presumably, prospectively assigned beneficiaries use less care (on average) during the performance year relative to retrospectively assigned beneficiaries—resulting in average benchmark increases of 1 percent for ACOs that choose prospective assignment. CMS seeks comment on using a prospective assignment window for an ACO's regional blend when that ACO chooses prospective assignment.

Comment

The Commission supports CMS's proposal to use consistent assignment windows in benchmark calculations. Differences in assignment windows can lead to undesirable incentives, which the Commission has previously noted.³⁰ In addition, the issue of inconsistent assignment windows is one of several issues that have arisen from the regional adjustment to benchmarks. As discussed previously in this letter, CMS should also consider phasing out the regional adjustment (see *Adjusting benchmarks to account for an ACO's prior savings and reduce negative regional adjustments*).

Applying the 3 percent cap on risk scores after first allowing for demographic risk score changes

The risk adjustment model (known as the CMS-hierarchical condition category (CMS-HCC) model) uses beneficiary demographic information (e.g., age, sex, original Medicare entitlement due to disability) along with diagnostic information from certain fee-for-service claims from the prior calendar year to calculate a coefficient for each demographic characteristic and medical condition in the model. Demographic characteristics and medical conditions with larger coefficients are associated with higher expected medical expenditures and vice versa. A risk score is the sum of the coefficients identified for a given beneficiary. CMS currently uses one year of

³⁰ Medicare Payment Advisory Commission. 2018. Comment letter on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule: Medicare Program: Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success. October 15. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/10152018_aco_2018_medpac_comment_v2_sec283312adfa9c665e80adff00009edf9c.pdf

diagnostic data to estimate the size of the coefficients and to identify diagnoses for risk scores. The 21st Century Cures Act permits the Secretary to use at least two years of diagnostic data in the calculation of the risk adjustment model. Beginning in 2020, CMS is phasing in the Alternative Payment Condition Count (APCC) CMS–HCC risk adjustment model, which is designed to improve the accuracy of risk adjustment for high-spending beneficiaries, including those with four or more health conditions.

In MSSP, CMS adjusts baseline expenditures in ACO benchmarks by making separate spending and risk score adjustments for assigned beneficiaries in each enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible). The national risk scores of assignable beneficiaries within each enrollment type are “renormalized” so that the average risk score within each enrollment type is equal to 1.0 (representing a beneficiary with average expected spending for that group). This adjustment accounts for the higher risk scores among the assignment-eligible population (i.e., those with a qualifying primary care visit relative to non-assignable FFS beneficiaries) and the change in risk scores for the national assignable population between an ACO’s baseline period and its performance year. This adjustment allows ACOs to increase the proportion of their ESRD, dual-eligible, and disabled populations without being penalized.

CMS further adjusts baseline expenditures to account for changes in assigned beneficiary HCC risk scores between the baseline and performance years. CMS makes separate adjustments for assigned beneficiaries in each enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible). Increases in baseline expenditures in MSSP benchmarks due to risk score changes are subject to a cap of 3 percent for each performance year in each enrollment type. ACO stakeholders have expressed concerns that this 3 percent risk score cap on MSSP benchmark adjustments does not account for risk score growth in the ACO’s regional service area.

CMS proposes to balance the interests of ACOs with its concerns about coding intensity by allowing for a 3 percent increase in risk scores after accounting for changes to an ACO’s demographic risk score. Changes to the demographic risk score would be calculated separately for each enrollment type and aggregated at the ACO level by the dollar-weighted demographic risk score changes. This aggregate demographic risk score change plus the 3 percent cap on risk scores would represent each ACO’s aggregate risk score cap. This cap would be separately applied to each enrollment type. In its simulations of 2020 ACO participants, CMS found that 45 percent of ACOs would have had increases to their benchmarks, 5 percent of ACOs would have had decreases, and 50 percent of ACOs would have been unaffected. CMS seeks comment on its proposal to determine an ACO’s risk score cap by combining changes to an ACO’s demographic risk score with a 3 percent cap on risk scores.

Comment

We support CMS’s proposal to include the full change in an ACO’s demographic risk score, but we strongly urge CMS to implement this change with a simultaneous decrease to the current 3 percent cap on risk score. As we stated in our September 2021 comment letter (on the CY 2022 proposed rule on the physician fee schedule), in general, we would expect changes in an ACO’s population to be accounted for by the HCC model, and the current 3 percent potential increase to benchmarks—in addition to being susceptible to rewarding ACOs for coding—would likely cover

anomalies when ACO populations have outlying deteriorating health status.³¹ Part of the impetus for allowing risk scores to increase by 3 percent was that it would better account for demographic changes that are largely out of an ACO's control.

There is no evidence that justifies maintaining the full 3 percent allowance on coding after accounting for demographic risk score changes. This increase in overall MSSP benchmarks presumes that CMS expects ACOs' assigned populations to become sicker more rapidly than the national population of assignable beneficiaries within each enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible). However, CMS's own analyses throughout the notice suggest that the opposite is true. For example, CMS notes that higher spending populations are increasingly underrepresented in MSSP since the change to regionally adjusted benchmarks. CMS also notes that ACO-assigned beneficiaries are disproportionately either Non-Hispanic White or not eligible for Medicaid. Yet despite the fact that the non-ACO population is increasingly comprised of higher spending beneficiaries and medically complex patients, the growth in risk scores for this population has been slower than that of beneficiaries assigned to ACOs. In addition, we have observed that the renormalized average risk score of beneficiaries assigned to an ACO has increased despite no overall increases to the renormalized demographic risk scores of beneficiaries assigned to an ACO.³² This strongly suggests that the increase in ACO risk scores has mainly resulted from their coding efforts. Keeping the full 3 percent allowance in risk scores would primarily benefit ACOs that serve disproportionately more white and non-dual-eligible beneficiaries. Furthermore, one study that examined ACO risk score growth between 2013 and 2016 found that the expected increase in ACO risk scores was less than 1 percent over the period; however, the observed increase in ACO HCC risk scores was over 6 percent during the period—

³¹ Medicare Payment Advisory Commission. 2021. Comment letter on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule: Medicare program; CY 2022 payment policies under the physician fee schedule and other changes to Part B payment policies; Medicare Shared Savings Program requirements; Provider enrollment regulation updates; provider and supplier prepayment and post-payment medical review requirements. September 9. https://www.medpac.gov/wp-content/uploads/2021/10/09092021_PartB_CMS1751_MedPAC_Comment_V2_SEC.pdf.

³² We calculated the average renormalized risk scores for assignable beneficiaries in 2015, 2017, and 2019 (applying the 2022 MSSP assignment methodology across all years, using risk scores under Version 22 of the CMS-HHC risk score model, and calculating demographic risk scores based on age/sex and applicable Medicaid and disability factors). We calculated risk scores by enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible aged), weighted risk scores by months of coverage with both Part A and Part B, and renormalized both risk scores and demographic risk scores within each enrollment type to a 1.0 average (reflecting the MSSP's methodology). Beneficiaries assigned to an ACO were those who were assigned to an MSSP ACO in the prior year (reflecting beneficiaries who would have been influenced by MSSP coding incentives). We found the following: between 2015 and 2019, the average ACO demographic risk score was nearly unchanged for beneficiaries who were non-dual eligible and aged, but their average overall risk score increased by about 5 percent. For beneficiaries who were dual eligible and aged, their average ACO demographic risk score decreased by about 2 percent, but their overall risk score increased by about 4 percent. For beneficiaries who were disabled, their average demographic risk score was nearly unchanged, but their overall risk score increased by about 3 percent. For assignable beneficiaries who were not assigned to an ACO, demographic risk scores were nearly unchanged across all enrollment types, but overall risk scores somewhat decreased during the period. All these patterns were similar (but with a lower magnitude) when examining changes in risk scores between 2017 and 2019.

strongly suggesting that the vast majority of the increase in ACO risk scores was driven by coding efforts rather than deteriorating health status.³³

As we described in our September 2021 comment letter, prior to any consideration of a policy that would increase MSSP coding incentives (e.g., allowing more than a 3 percent increase in benchmarks due to risk score changes), CMS should address the underlying incentives for coding intensity and the accuracy of risk adjustment.³⁴ For example, the Commission's March 2016 recommendation to use two years of diagnostic data for calibration of the risk score model and risk scores would both improve the accuracy of risk score coefficients and reduce year-to-year variation in beneficiary risk scores.³⁵ In addition, the Commission's June 2022 report to the Congress discussed a method for limiting the effect that outliers (i.e., beneficiaries with the largest underpredictions and overpredictions in spending) have on risk score coefficients. The Commission's analysis showed that this change would improve the accuracy of predicted spending by the risk-adjustment model, especially for medically complex beneficiaries. Until CMS is willing to consider underlying changes that directly affect coding incentives or provide an empirical justification for a 3 percent allowance of coding (after allowing demographic risk score changes), the agency should consider applying a uniform coding adjustment across all ACOs to offset the increases to benchmarks via coding increases. This adjustment would protect the Medicare program from subsidies given to ACOs for their coding efforts. To the extent CMS considers any coding allowance (including for regional differences in risk scores), CMS should apply an adjustment that ensures the average increase in risk scores across all ACOs is no greater than the average for the assignable population. To mitigate coding incentives, CMS could group ACOs into categories of high, medium, and low coding intensity and then apply a coding intensity adjustment based on the average level of coding intensity for each group (similar to an option the Commission discussed in its March 2017 report to the Congress).³⁶

ACOs should meet the minimum savings rate (MSR) to share in savings

The MSR was established to account for normal variation in spending that can occur without any ACO activity so that only ACOs that achieve sufficient savings that are likely to reflect real quality and efficiency gains would be able to share in them (similarly, there is a minimum loss ratio for ACOs under two-sided risk). The MSR protects the Trust Fund from making payments based on random variation from year-to-year, but if set too high, it may discourage potentially successful ACOs from participating in the program. The MSR varies inversely with ACO size since spending

³³ Chernenov, M. E., J. Carichner, J. Impreso, et al. 2021. Coding-driven changes in measured risk in accountable care organizations. *Health Affairs* 40, no. 12 (December). <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.00361>.

³⁴ Medicare Payment Advisory Commission. 2021. Comment letter on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule: Medicare program; CY 2022 payment policies under the physician fee schedule and other changes to Part B payment policies; Medicare Shared Savings Program requirements; Provider enrollment regulation updates; provider and supplier prepayment and post-payment medical review requirements. September 9. https://www.medpac.gov/wp-content/uploads/2021/10/09092021_PartB_CMS1751_MedPAC_Comment_V2_SEC.pdf.

³⁵ Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

³⁶ Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

variability varies inversely with size (ranging from 3.9 percent for ACOs with 5,000 assigned beneficiaries to 2.0 percent for ACOs with 60,000+ assigned beneficiaries for ACOs in the one-sided levels of the BASIC track). Thus, the MSR may act as bigger deterrent to participation for small ACOs. CMS proposes to allow ACOs to share in savings without meeting the MSR if they (a) have average per capita spending below the updated benchmark; (b) are low revenue; (c) have at least 5,000 assigned beneficiaries; and (d) meet the quality performance standard. Eligible ACOs would receive half of the maximum shared savings rate they normally would if they met the MSR.

Comment

The Commission does not support waiving the MSR and enabling ACOs that did not achieve sufficient savings to exceed the MSR to share in those savings, even at a lower rate. As CMS notes, the MSR is intended to provide some level of confidence in an ACO's savings—particularly for ACOs in one-sided risk arrangements. Even under current MSR requirements, some have contended that the performance of smaller ACOs is driven by random variation.³⁷ In addition, this policy is targeted toward low-revenue ACOs, but CMS indicates in this notice that the share of participating ACOs that meet the definition of low-revenue ACO has increased by 8 percentage points over three participation years in a consistent upward trajectory. In fact, 56 percent of MSSP ACOs are currently classified as low revenue. Furthermore, given that nearly 90 percent of MSSP ACOs receive higher benchmarks through a positive regional adjustment, the majority of ACOs that would benefit from this policy would be those that also benefit from selection against high-spending, medically complex, and underserved populations.

We believe that there are other, more direct methods (many of which are proposed by CMS in the NPRM) to increase participation in the program. We believe the MSR is important for protecting the Trust Fund from making payments based solely on random variation, and that the establishment of the threshold should be data and statistically driven.

Adding a health equity quality adjustment in the quality score

CMS proposes to implement a health equity adjustment to an ACO's quality performance score to recognize high quality performance by ACOs with large underserved populations. This proposed adjustment would add up to 10 bonus points to the ACO's quality performance score if they met established criteria. CMS intends for the health equity adjustment to support those ACOs serving a high proportion of underserved individuals, while also encouraging all ACOs to treat underserved populations.

Comment

CMS's proposed approach to add a health equity adjustment to the ACO quality scores is generally consistent with the Commission's principles for quality payment programs. The Commission asserts that providers that treat a large share of patients with adverse social risk factors may be relatively disadvantaged in a quality payment program because it may be harder for them to achieve good

³⁷ Barr, L. A. Loengard, L. Hastings, et al. 2018. Payment reform in transition—Scaling ACOs for success. *Health Affairs* blog. May 11. <https://www.healthaffairs.org/doi/10.1377/forefront.20180507.812014/full/>.

outcomes for their patients. Thus, a quality payment program should account for differences in the providers' patient populations to counter the disadvantages they could face in achieving good outcomes. Rather than adjusting performance measures for patients' social risk factors, which can mask disparities in performance, Medicare should make adjustments to payments based on a provider's performance compared with its peers. Although the methodology to calculate the health equity adjustment is different than the peer grouping approach the Commission has used in its design of other quality payment programs, the intent is similar. An ACO's performance is compared with ACOs that treat a similar mix of patients at high social risk (that is, its "peers") to determine whether an ACO should receive bonus points based on their quality performance.

To further address health care disparities and advance health equity, we encourage CMS to collect, calculate, and report ACO quality measure results that are stratified by subgroups of the underserved population, for example by LIS. Access to stratified quality measure results could inform ACO quality improvement efforts. This information will also allow CMS to monitor if the health equity adjustment and other policy changes in the ACO program are reducing health care disparities.

Quality Payment Program—qualifying alternative payment model participant (QP) determinations

Each year, CMS calculates the percent of a clinician's payments and patients in advanced alternative payment models (A-APMs) (e.g., Medicare Shared Savings Program, Comprehensive Care for Joint Replacement, Primary Care First). If either of these percentages is above a certain threshold, a clinician is considered to be a Qualifying APM Participant (QP) and is exempt from the Merit-based Incentive Payment System (MIPS)'s performance-based payment adjustments (which can be positive or negative). QPs face different payment policies in different periods:

- From 2019 through 2024, QPs receive an annual bonus worth 5 percent of their Medicare payments for professional services, in addition to any bonuses or penalties available through their A-APM.
- In 2025, QPs will not receive a 5 percent bonus and will continue to be subject to bonuses or penalties through their A-APM.
- Starting in 2026, QPs will receive higher annual updates to their Medicare physician fee schedule payment rates (0.75 percent) than non-QPs (0.25 percent) and will continue to be subject to bonuses or penalties through their A-APM.

In all of these periods, clinicians who participate in A-APMs but do not meet the criteria to be considered QPs receive MIPS payment adjustments (which have historically been positive for most clinicians).

When determining whether a clinician is a QP, CMS usually makes this determination at the APM entity level. APM entities are groups of clinicians who agree to be held responsible collectively for cost and quality targets (e.g., an accountable care organization, a hospital paid through an episode-based payment model, a practice in Primary Care First). When determining QP status at the APM

entity level, CMS includes the payments and patients of all of the clinicians in that entity when calculating the percent of payments or patients in A-APMs; if one of these two percentages exceeds a certain threshold percentage, all of the clinicians in the APM entity are considered QPs.

In this proposed rule, CMS requests feedback on a potential policy that would make QP determinations at the individual clinician level rather than at the APM entity level. One rationale for such a change is that making QP determinations at the APM entity level results in some clinicians earning QP status even though they would not have qualified as a QP on their own. CMS also notes that a clinician who has a high percent of payments or patients in an A-APM could potentially fail to earn QP status if other clinicians in their APM entity have low shares of payments or patients in an A-APM.

Comment

We acknowledge the tradeoffs between making QP determinations at the APM entity level versus the individual clinician level. An APM entity faces the risks and rewards of participation in an A-APM (e.g., shared savings or shared losses) as a single unit, so it makes sense that any payment policies tied to being a QP should also apply to all of the clinicians in that APM entity. However, doing so may create opportunities for gaming: APM entities can strategically exclude clinicians with low shares of patients or payments in A-APMs to ensure a QP determination (or, conversely, can strategically *include* these clinicians in order to *avoid* a QP determination³⁸). And although there is a certain logic to tying individual clinician's QP status to their individual behavior, making QP determinations at the clinician level raises concerns about clinicians unexpectedly gaining or losing QP status from one year to the next due to random variation in the composition of a clinician's patient panel (due to small sample sizes). There may be other ways to determine QP status (e.g., using all of the clinicians associated with an *organization*), but no option is perfect. Absent a compelling reason to change how QP determinations are made, it may be sensible to maintain the status quo.

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please do not hesitate to contact James E. Mathews, MedPAC's Executive Director, at 202-220-3700.

Sincerely,



Michael E. Chernew, Ph.D.
Chair

³⁸ In the proposed rule, CMS notes that although QP status has historically yielded larger payments for high-performing A-APM clinicians than MIPS adjustments, the opposite is expected to be true in some upcoming years.