



Medicare Payment
Advisory Commission

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Chiquita Brooks-LaSure, M.P.P.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
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Attention: CMS-1784-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 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program" published in the *Federal Register*, vol. 88, no. 150, pages 52262 to 53197 (August 7, 2023). 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 also appreciate the inclusion of page numbers in the display copy of the rule this year!) We hope that the comments we offer below are helpful.

Our comments address the following provisions in the proposed rule:

- Payment for Medicare telehealth services
- Office/outpatient evaluation and management (E&M) visit complexity add-on code
- Request for comment about evaluating E&M services more regularly and comprehensively
- Drugs and biological products paid under Medicare Part B
- Medicare Shared Savings Program
- Incorporating Medicare Advantage (MA) data into public reporting

Payment for Medicare telehealth services

Under the physician fee schedule (PFS), Medicare covered a limited set of telehealth services in rural locations before the public health emergency (PHE). CMS paid clinicians performing a

telehealth visit the PFS's lower, facility-based payment rate instead of the higher, nonfacility (office-based) rate. During the PHE, CMS expanded Medicare's coverage of telehealth services (by expanding the services that can be provided via telehealth and allowing telehealth services to be provided in urban areas) on a temporary basis. In addition, CMS changed the payment rate for these services to equal the rate it would pay if the telehealth service had been provided in person (the PFS's facility rate or nonfacility rate, depending on the clinician's location). As required by the Consolidated Appropriations Act, 2023, CMS now proposes to extend expanded coverage of telehealth through calendar year (CY) 2024. CMS also proposes to pay for telehealth services provided in a patient's home at the higher nonfacility rate for CY 2024.

Comment

The Commission does not support CMS's proposal to pay the higher, nonfacility rate for telehealth services provided in a patient's home. As discussed in our March 2021 and June 2023 reports to the Congress, the Commission supports returning to the pre-PHE policy of applying the lower, facility payment rate for all telehealth services, unless cost data from practices and other entities indicate that a higher payment rate is warranted.¹

CMS's proposal is a departure from prior rulemaking. In 2022, CMS proposed to return to paying the facility rate for telehealth services after the end of the PHE. However, CMS did not finalize that policy; instead, the agency finalized a policy to continue the PHE policy of paying the rate that would apply if the service were performed in-person through CY 2023.

In this year's proposed rule, CMS suggests that paying the office-based rate for telehealth services provided in a patient's home in CY 2024 is warranted because practitioners (specifically in behavioral health settings) are maintaining their in-person practices, even as significant proportions of their practices' utilization is comprised of telehealth services. CMS does not provide any data to support this assertion. In addition, CMS's justification for paying the higher, nonfacility rate for all telehealth services furnished in a patient's home is based on one group of services (behavioral health) and does not discuss why it would thus be appropriate to pay other services the higher rate as well.

We urge CMS to gather more data on the practice expenses associated with telehealth services for a range of services before paying the higher, nonfacility rate. Since the widespread adoption of telehealth in 2020, clinicians and the organizations that employ them (e.g., hospitals) may have found ways to deliver care more efficiently using telehealth. For example, practitioners providing telehealth services may have determined that they require less clinical support staff (i.e., medical assistants are not needed for rooming patients for a telehealth visit) or may have maintained an in-person practice but downsized the size of their office (e.g., if some clinicians work remotely some or all of the time). If this occurred, then practice expenses may be lower for practitioners who provide both in-person and telehealth services. In addition, clinicians who utilize telehealth may

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

Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

also realize additional efficiencies in the future (e.g., downsizing office space as longer term leases come up for renewal), which further suggests the need to collect and monitor the practice expense data.

Further, if rates for telehealth services continue to be set equal to rates for in-office services, providers may face a strong financial incentive to favor these services over comparable in-person services, even when an in-person service may be more clinically appropriate.

Office/outpatient evaluation and management visit complexity add-on code

Under the PFS, clinicians bill for office/outpatient (O/O) evaluation and management (E&M) visits using four billing codes for new patients and five codes for established patients. As the time clinicians spend or the complexity of the medical decision making required during the visit increases, clinicians bill higher-paid codes. For example, for established patients, clinicians may bill code 99213 when 20–29 minutes is required for the visit and code 99214 when 30–39 minutes is required.² Once clinicians exceed the highest-level code (e.g., code 99215 for established patients, 40–54 minutes), they may bill an add-on code (G2212) to receive payment for each additional 15 minutes they spend with the patient.

In 2021, CMS revalued the O/O E&M codes, which resulted in material increases in the work RVUs (and therefore payment rates) for several of these codes. For example, the work RVUs for code 99214 rose from 1.50 to 1.92, an increase of 28 percent.

However, CMS stated that the agency believed these increased valuations still did not account for the resources involved in furnishing certain kinds of care included in the O/O E&M visit code set. Therefore, in the CY 2021 PFS final rule, CMS finalized an add-on code (G2211) that could be reported in conjunction with O/O E&M visits to better account for additional resources associated with primary care, or similarly ongoing medical care related to a patient's single, serious condition, or complex condition.

After CMS issued the CY 2021 PFS final rule, the Consolidated Appropriations Act, 2021, imposed a moratorium on Medicare payment for this add-on code before January 1, 2024. Accordingly, prior to 2024, the add-on code could be reported, but Medicare could not make a separate payment for it.

In the current proposed rule, CMS proposes to make the add-on code separately payable beginning in 2024, with a work RVU of 0.33. The code's full description is:

Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or

² The time ranges included for these codes include the time spent with the beneficiary and time the clinician spends before and after the visit on the same day of the encounter for activities such as reviewing the patient's history and documenting the encounter in the medical record. When using time to select the appropriate code, only time spent on the day of the encounter is included. However, when the codes are valued for payment purposes, activities three days before the visit and seven days after the visit for activities such as reviewing diagnostic data and answering follow-up questions are included.

with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established.)

Comment

The Commission has a long-standing body of work focused on supporting primary care clinicians and accurately valuing E&M services,³ and we appreciate CMS's continued focus on ensuring that primary care clinicians and other clinicians who largely bill E&M services are accurately and appropriately paid. However, we do not support the agency's proposed add-on code to O/O E&M visits because there continues to be too much ambiguity regarding the code's use and the costs it is intended to cover. Though CMS has provided more details in this proposed rule than in previous ones about how the code would be used (for example, CMS now notes that the add-on code would not be payable when reported with a payment modifier of -25 and should not be used when a visit is furnished by a clinician whose relationship with the patient is of a discrete, routine, or time-limited nature (e.g., mole removal, treatment of a simple virus, treatment of a fracture, or counseling related to seasonal allergies)),⁴ further clarity is needed. Specifically, it is unclear the extent to which the add-on code is intended to pay for additional work intensity resulting from concurrently addressing multiple health complaints in a single visit, additional clinical staff time or supplies expended during a visit, or additional non-face-to-face activities associated with furnishing comprehensive, longitudinal care. Without further clarification, the code is at risk of being misused and could potentially duplicate payments for other services, either now or in the future as more codes are added to the PFS. For example, over the last several years, CMS has added several services that are intended to pay for care management or other non-face-to-face services (e.g., chronic care management, principal care management, responding to patient portal messages, and remote patient monitoring); some of these newly added services are related to the provision of longitudinal, comprehensive care. To prevent duplicative payment, CMS must specify the types of activities the new add-on code is intended to cover.

Moreover, to the extent the add-on code is intended to cover the higher levels of complexity of certain face-to-face visits, CMS should explain why the current O/O E&M code set is not

³ Medicare Payment Advisory Commission. 2008. "Promoting the use of primary care," in *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2015. "Physician and other health professional services," in *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2018. "Rebalancing Medicare's physician fee schedule toward ambulatory evaluation and management services," in *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2019. Increasing the supply of primary care physicians: Findings from stakeholder interviews. Presentation at the Commission's November public meeting.

Medicare Payment Advisory Commission. 2022. Policy options for increasing Medicare payments to primary care clinicians. Presentation at the Commission's November public meeting.

Medicare Payment Advisory Commission. 2023. "Physician and other health professional services," in *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

⁴ Modifier 25 is used to indicate that a patient's condition required a significant, separately identifiable E&M service above and beyond that associated with another procedure or service that is being reported by the same clinician on the same date.

sufficient. Because clinicians can use different levels of E&M codes to indicate whether an E&M visit took longer or required more complex medical decision making, it is unclear why an add-on code is needed to account for the additional resources required for more complex visits.

We have previously recommended increasing payments to primary care clinicians without detailing specific activities these payments are meant to cover. Our recommendations have been intended to counteract misvaluations in the fee schedule that have led to overvaluation of non-E&M services. Our prior recommendations differ from the add-on code proposed here in that our recommendations would be more narrowly targeted at primary care clinicians and would not create a new fee schedule billing code. Fee schedule billing codes should be based on the relative amount of resources needed to deliver a service. Introducing a code into the fee schedule that is not clearly resource-based would create a problematic precedent. Instead, the Commission has recommended using mechanisms other than the fee schedule's billing codes to direct new payments to primary care clinicians (e.g., payment adjustments, per beneficiary payments).⁵

If CMS decides to implement the add-on code, we encourage the agency to add further clarifications or claim edits to help prevent underuse or overuse. For example, if the add-on code becomes payable in 2024, CMS should monitor utilization data and make further refinements to better target the code on an ongoing basis. In addition, we would strongly support implementing the add-on code in a budget-neutral manner. Doing so would help protect beneficiaries and taxpayers (who jointly finance the program) from increases in costs. Since CMS's impact analyses suggest that the effects of this policy would be modest, imposing budget neutrality is unlikely to affect beneficiary access to care.⁶ Nevertheless, as the Commission does every year, we will continue to monitor access to care for beneficiaries to both specialists and primary care clinicians.

Request for comment about evaluating E&M services more regularly and comprehensively

In this year's proposed rule, CMS requests comments on how the agency could improve the processes and methodologies used to value services in the physician fee schedule. CMS notes that over the last several years, it has received suggestions to move away from its current approach of relying heavily on recommendations from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) when establishing services' values, and to instead use research and data from other sources. Such suggestions have been made due to concerns about growing distortions in resource allocations in the fee schedule for certain types of services, such as E&M visits and other nonprocedural/nonsurgical services. CMS now seeks comments on a number of questions, including whether the methods currently used by the RUC and CMS accurately value

⁵ Medicare Payment Advisory Commission. 2008. "Promoting the use of primary care," in *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2015. "Physician and other health professional services," in *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2023. "Physician and other health professional services," in *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

⁶ As a result of all changes included in the CY 2024 proposed rule (and not just the E&M add-on code), CMS estimates that the specialties that will experience the largest decrease in allowed charges are interventional radiology (4 percent), nuclear medicine (3 percent), radiology (3 percent), and vascular surgery (3 percent). In contrast, CMS estimates that endocrinology and family practice will experience the largest increase (3 percent).

E&M and non-E&M services; whether existing E&M codes define the full range of E&M services with appropriate gradations for intensity of services; what the consequences are if services are not accurately defined or valued; how CMS could improve the accuracy of services' values in the fee schedule; and whether the RUC is best positioned to provide recommendations to CMS on services' values or whether another independent entity would better serve CMS.

Comment

Each billing code in the physician fee schedule is assigned a certain number of relative value units (RVUs), which account for the amount of clinician work required to provide a service, expenses related to maintaining a practice, and professional liability insurance costs. The Commission and other researchers have pointed out long-standing problems with the data and processes used to set different services' RVUs, which have led to certain services (e.g., procedures, imaging, and tests) becoming overvalued relative to other services (e.g., E&M services).⁷ We have put forward several approaches for improving the accuracy of RVUs in our prior recommendations to the Congress and comment letters to CMS, which we reiterate here.

CMS relies heavily on RUC recommendations when setting RVUs.⁸ Yet most of the RUC's members have a financial stake in the process of setting payment rates, and researchers have expressed concerns about the RUC's transparency and objectivity and the quality of the data it uses to estimate work RVUs.⁹ In 2006, we recommended that CMS augment the RUC with a

⁷ Government Accountability Office. 2015. *Medicare physician payment rates: Better data and greater transparency could improve accuracy*. GAO-15-434. Washington, DC: GAO.

Crespin, D. J., A. M. Kranz, T. Ruder, A. Mehrotra, and A. W. Mulcahy. 2021. *Claims-based reporting of post-operative visits for procedures with 10- or 90-day global periods: Updated results using calendar year 2019 data*. Santa Monica, CA: RAND Corporation.

Laugesen, M. J. 2016. *Fixing medical prices: How physicians are paid*. Cambridge, MA: Harvard University Press.

Medicare Payment Advisory Commission. 2018. "Rebalancing Medicare's physician fee schedule toward ambulatory evaluation and management services," in *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Merrell, K., C. Schur, T. Oberlander, et al. 2014. *Analysis of physician time use patterns under the Medicare fee schedule*. Report prepared for the Assistant Secretary for Planning and Evaluation. Washington, DC: Social & Scientific Systems and the Urban Institute.

Zuckerman, S., K. Merrell, R. Berenson, et al. 2016. *Collecting empirical physician time data: Piloting an approach for validating work relative value units*. Report prepared for the Centers for Medicare & Medicaid Services. Washington, DC: The Urban Institute.

Berenson, R. A., P. B. Ginsburg, K. J. Hayes, et al. 2022. Comment letter to the Centers for Medicare & Medicaid Services on NPRM calendar year 2023 payment policies under the physician fee schedule and other changes to Part B payment policies, Medicare Shared Savings Program requirements, etc. File code no. CMS-1770-P. September 2.

<https://www.urban.org/sites/default/files/2022-09/Medicare%20Physician%20Fee%20Schedule%20Comment%20Letter.pdf>.

⁸ The RUC recommends work RVUs and direct inputs for practice expense RVUs, such as the type and quantity of medical equipment, medical supplies, and nonphysician clinical staff time involved in delivering a service. According to the RUC, CMS accepts more than 90 percent of the RUC's recommendations each year. (American Medical Association. 2022. *2022 RVS update process: AMA/Specialty Society*. Chicago, IL: AMA. <https://www.ama-assn.org/system/files/ruc-update-booklet.pdf>.)

⁹ Government Accountability Office. 2015. *Medicare physician payment rates: Better data and greater transparency could improve accuracy*. GAO-15-434. Washington, DC: GAO.

standing panel of experts that could help the agency identify overvalued services and review recommendations from the RUC.¹⁰ We proposed that this group include members with expertise in health economics and physician payment as well as members with clinical expertise.

To improve the accuracy of the data used to determine RVUs, the Commission recommended in 2011 that CMS regularly collect data on service volume and clinician work time from a cohort of efficient practices.¹¹ In 2015, we elaborated on this recommendation by proposing a “top-down” approach to validate RVUs.¹² This method would use data collected from practices to look at the amount of time that a clinician worked over the course of a week or month and compare it with the time estimates in the fee schedule for all of the services that the clinician billed for over the same period. If the fee schedule’s time estimates exceeded the actual time worked, this finding could indicate that the time estimates—and, hence, the RVUs—were too high. In 2015, we described findings from a feasibility study we commissioned that collected data from a small set of physician practices on the services billed by their physicians and clinicians’ actual hours worked and found that fee schedule time far exceeded physicians’ hours worked for orthopedists and cardiologists.¹³ CMS could use this “top-down” approach to identify groups of services that are likely overpriced, carefully review those services, and adjust the work RVUs accordingly.

Although a wide range of codes likely warrant reexamination using new data and analyses, one set of codes are in particular need of revaluation: 10- and 90-day global surgical codes. Currently, the payment rate for most surgical services is a bundled payment that includes the procedure itself and certain services that are provided immediately before and after the procedure by the clinician performing a surgery; CMS calls this group of services the global package. There are three categories of global billing codes based on the number of postoperative days included in the package: 0-day global codes, which include the procedure and preoperative and postoperative clinician services on the day of the procedure; 10-day global codes, which include the same services as the 0-day global codes plus clinician visits related to the procedure during the 10 days after the procedure; and 90-day global codes, which include the same services as the 0-day global codes plus preoperative services furnished one day before the procedure and clinician visits related to the procedure during the 90 days after the procedure. Of the approximately 8,000 billing codes in the physician fee schedule, half are global codes.

Laugesen, M. J. 2016. *Fixing medical prices: How physicians are paid*. Cambridge, MA: Harvard University Press.
Berenson, R. A., P. B. Ginsburg, K. J. Hayes, et al. 2022. Comment letter to the Centers for Medicare & Medicaid Services on NPRM calendar year 2023 payment policies under the physician fee schedule and other changes to Part B payment policies, Medicare Shared Savings Program requirements, etc. File code no. CMS-1770-P. September 2. <https://www.urban.org/sites/default/files/2022-09/Medicare%20Physician%20Fee%20Schedule%20Comment%20Letter.pdf>.

¹⁰ Medicare Payment Advisory Commission. 2006. “Reviewing the work relative values of physician fee schedule services,” in *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

¹¹ Medicare Payment Advisory Commission. 2011. Moving forward from the sustainable growth rate system. Letter to the Congress. October 14. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/10142011_MedPAC_SGR_letter.pdf.

¹² Medicare Payment Advisory Commission. 2015. “Physician and other health professional services,” in *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

¹³ Ibid.

Because it is difficult to accurately account for the number of visits included in 10- and 90-day global surgical codes, CMS finalized a policy in 2014 that would have converted all of these codes to 0-day global codes and allowed clinicians to bill separately for each postoperative visit, which we supported.¹⁴ Subsequently, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) stopped CMS from implementing this change on CMS's planned timeline and mandated that CMS gather data to appropriately value postoperative care in global codes.

Since collecting the required data, CMS's grounds for converting 10- and 90-day global surgical codes to 0-day global codes have only grown stronger. After collecting data on the number of postoperative visits provided in nine states, RAND researchers working for CMS found that a majority of the postoperative visits that Medicare intended to pay for as part of these global codes are not being provided. For procedures with 10-day global periods, only 4 percent of the expected postoperative visits are provided, and for procedures with 90-day global periods, only 38 percent of expected postoperative visits are provided.¹⁵ RAND has estimated that if payment rates for 10- and 90-day global surgical codes were reduced to reflect the actual number of postoperative visits being provided, total Medicare payments to certain surgical specialties would decline by as much as 17 to 18 percent.¹⁶

Because of the evidence of the substantial overvaluation of 10- and 90-day surgical global codes, the Commission has continued to support CMS's prior proposal to convert all 10- and 90-day global surgical codes to lower-priced 0-day global codes and allow practitioners to separately bill for postoperative visits on a fee-for-service basis (i.e., outside of the global package).¹⁷ We believe this transition could be implemented relatively quickly and easily, by simply subtracting the RVUs

¹⁴ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2014. Medicare program; revisions to payment policies under the physician fee schedule, clinical laboratory fee schedule, access to identifiable data for the Center for Medicare and Medicaid Innovation models & other revisions to Part B for CY 2015. Final rule. *Federal Register* 79, no. 219 (November 13): 67547–68092.

Medicare Payment Advisory Commission. 2014. Letter commenting on CMS's proposed rule entitled: "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015." August 28. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/08282014_comment_letter_2015_pt_b_rule_final.pdf.

¹⁵ Crespin, D. J., A. M. Kranz, T. Ruder, A. Mehrotra, and A. W. Mulcahy. 2021. *Claims-based reporting of post-operative visits for procedures with 10- or 90-day global periods: Updated results using calendar year 2019 data*. Santa Monica, CA: RAND Corporation.

¹⁶ Mulcahy, A. W., H. H. Liu, T. Ruder, et al. 2019. *Using claims-based estimates of post-operative visits to revalue procedures with 10- and 90-day global periods*. Santa Monica, CA: RAND.

¹⁷ Medicare Payment Advisory Commission. 2019. MedPAC letter commenting on CMS's proposed rule entitled: "Medicare Program; CY 2020 revisions to payment policies under the physician fee schedule and other changes to Part B payment policies; Medicare Shared Savings Program requirements; Medicaid Promoting Interoperability Program requirements for eligible professionals; establishment of an ambulance data collection system; updates to the quality payment program; Medicare enrollment of opioid treatment programs and enhancements to provider enrollment regulations concerning improper prescribing and patient harm; and amendments to physician self-referral law advisory opinion regulations." September 13. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/09132019_cms_1715p_physician_medpac_comment_v2_sec.pdf.

related to postoperative visits from each global code's RVUs.¹⁸ Retaining 10- and 90-day global codes but revaluing them is also an option, but would take longer and be more complicated, since it would involve identifying new estimates of the appropriate number of postoperative visits for each 10- and 90-day global code, one by one. It would also produce inaccurate payments whenever the number of postoperative visits actually provided diverges from the number assumed to be included in the global code's package of services.

When subsets of services are overvalued, it causes the gap between the compensation of different clinical specialties to be larger than it otherwise would be. In 2021, the median compensation for surgical specialties was \$441,000—well above the \$264,000 that primary care physicians earned.¹⁹ This large compensation gap makes careers as primary care providers less financially attractive than careers as specialists and may be a factor in why the supply of primary care physicians in the U.S. has been declining in recent years.

Drugs and biological products paid under Medicare Part B

For new Part B drugs, CMS proposes to codify two statutory provisions concerning payment for these products in the initial quarters when they lack average sales price (ASP) data:

- The Sustaining Excellence in Medicaid Act of 2019 requires Medicare to pay for new Part B drugs in the initial period when they lack ASP data based on (1) an amount not to exceed 103 percent of wholesale acquisition cost (WAC) or (2) payment methods in effect as of November 1, 2003. In the 2019 rulemaking, CMS established a payment rate of WAC+3 percent for new drugs lacking ASP data, but it did not update the regulation text. The CY 2024 proposed rule proposes to update the regulation text.
- Effective July 1, 2024, the Inflation Reduction Act places a cap on the payment rate for new biosimilars lacking ASP data; that payment amount is based on the same formula as other new drugs and biologics lacking ASP data (cited above), capped by the reference biologic's payment rate.

Comment

In the June 2023 report to Congress, to improve Medicare's Part B drug payment system, the Commission recommended eliminating add-on payments for drugs lacking ASP data that are paid based on WAC.²⁰ Based on the statutory language CMS proposes to codify, it appears that CMS has the authority to eliminate the 3 percent add-on payment for new drugs paid based on

¹⁸ Medicare Payment Advisory Commission. 2014. Letter commenting on CMS's proposed rule entitled: "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015." August 28. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/08282014_comment_letter_2015_pt_b_rule_final.pdf.

¹⁹ Medicare Payment Advisory Commission. 2023. "Physician and other health professional services," in *Report the Congress: Medicare payment policy*. Washington, DC: MedPAC.

²⁰ Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC

WAC. Therefore, we urge the Secretary to reduce the payment rate for new drugs lacking ASP data from 103 percent to 100 percent of WAC. Because WAC is generally a higher price than ASP and does not reflect discounts, eliminating the WAC add-on would reduce excess payments, increase affordability for beneficiaries and taxpayers, and improve financial incentives.

In our June 2023 report to the Congress, the Commission also recommended policies that would address payment for drugs approved under the accelerated approval pathway, spur price competition among drugs with similar health effects, and improve financial incentives under the Part B drug payment system. First, to address high launch prices for drugs and biologics with limited clinical evidence approved by the Food and Drug Administration under the accelerated approval pathway, we recommended that the Congress require the Secretary to cap the payment rate of Part B accelerated approval drugs (with limited circumstances for exceptions) if postmarketing confirmatory trials are not completed timely, if the product's clinical benefit is not confirmed in postmarketing confirmatory trials, or if the product is covered under a "coverage with evidence development" policy. The Commission also recommended that the Secretary be given the authority to cap Medicare payment for such drugs if their price is excessive relative to the upper-bound estimate of their value. Second, to promote price competition, the Commission recommended that CMS be given the authority to use reference pricing to set a single ASP-based payment rate for groups of drugs and biologics with similar health effects. The Secretary could begin with those reference groups for which implementation would be the most straightforward: (1) biosimilars and originator biologics; (2) 505(b)(2) drugs and related brand-name and generic drugs; and (3) drugs for which reference pricing has been implemented or considered previously, including erythropoietin-stimulating agents. Third, we recommended that financial incentives be improved by reducing add-on payments for costly Part B drugs paid based on ASP. To the extent that these policies recommended by the Commission are outside the Secretary's current authority, we urge the agency to seek additional statutory authority to pursue such policies.

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 and ACOs whose beneficiaries spend sufficiently below the benchmark share in a portion of savings. ACOs may also share in losses depending on the program track the ACO selected. CMS has adjusted the method for calculating the financial benchmark over the years to address concerns about unequal benchmarks for ACOs in the same market as well as to encourage ACOs that have decreased spending to remain in the program (otherwise these ACOs might see their benchmarks continually fall – the "ratchet effect"). Thus, current program guidelines calculate the benchmark as a blend of the ACO's historical spending and the fee-for-service spending for all assignable beneficiaries (i.e., those with at least one qualifying primary care visit) in an ACO's region (including the spending of the ACO's assigned population). The adjustment for regional spending works as follows: If an ACO's risk-standardized spending in the baseline is below spending in the region, the ACO's benchmark calculation is increased, but the amount of the increase is capped at 5 percent of national per capita expenditures (a positive regional adjustment). Similarly, if an ACO's risk-standardized spending in

the baseline is above spending in the region, the ACO's benchmark calculation is lowered by an amount capped at 1.5 percent (a negative regional adjustment).

In recent years, since the implementation of this regional adjustment, CMS has found that ACOs with already low spending compared to the region are far more likely to participate in the program, while higher-spending providers with more potential for savings are largely choosing not to participate. The overwhelming majority of ACO participants receive a positive regional adjustment to their benchmarks and can earn shared savings without achieving any additional efficiencies in care delivery. In 2022, 86 percent of participating ACOs had their benchmark increased because the ACO's historical baseline spending was lower than average spending in their region, increasing to 93 percent among ACOs under two-sided risk. The favorable selection by participants and increased incentives for coding has coincided with substantial growth in payments to ACOs through shared savings that are calculated relative to benchmarks. Indeed, in 2022, CMS paid approximately \$242 per beneficiary in earned shared savings compared to around \$90 per beneficiary each year between 2015 and 2018.²¹ In addition, no ACOs were liable for shared losses in 2022.

CMS has noted that this favorable selection is problematic for meeting the statutory program requirement not to increase Medicare spending (as well as its negative impact on the Trust Fund). In the CY 2023 PFS rule, CMS attempted to address this concern by introducing a variety of program updates to encourage participation and expansion into underserved communities. While the program updates finalized in that rule diminished or removed disincentives for higher-spending ACOs (and those in underserved communities) to join the program, they did little to discourage low-spending providers from selectively forming ACOs or to discourage providers from coding beneficiaries to make them appear more severely ill. That is, CMS's CY 2023 updates were financially favorable to nearly all ACOs in order to promote the agency's goal of having 100 percent of Medicare beneficiaries be in an accountable care relationship with providers that are responsible for quality and total cost of care by 2030.²²

This year, CMS proposes additional program updates aimed at attracting the formation of new ACOs, without producing disincentives for current ACO participants. These include:

- Further mitigating the impact of the negative regional adjustment (though CMS is also seeking comment on potential refinements to the positive regional adjustment).
- Enabling increases to benchmarks by capping the risk score growth in the regional trend calculation, analogous to the cap on the ACO risk score, but with adjustments for the ACO's market share.

²¹ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023. Shared Savings Program fast facts—As of January 1, 2023. Baltimore, MD, CMS. <https://www.cms.gov/files/document/2023-shared-savings-program-fast-facts.pdf>.

²² As of January 2023, 76 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 plan or other private plan. (Medicare Payment Advisory Commission. 2023. *A data book: Health care spending and the Medicare program*. Washington, DC: MedPAC.)

CMS also seeks comments on methodologies for determining the prior savings adjustment and the implementation of an administrative benchmark.

Comment

As we described in our comment letter on the 2023 proposed rule for MSSP, we find no evidence that policies allowing for greater influence of regional spending and coding on benchmarks has led to program savings.²³ Indeed, CMS has also found that the current favorable selection, if unmitigated, would result in net program losses over the next decade. The agency has stated that inducing new entrants is the key to returning the program to net savings.²⁴ However, since MSSP participation is voluntary, CMS has relied upon program policies designed to attract ACOs serving high-spending populations and has not discouraged participation by current, low-spending participants. While the Commission commends CMS's efforts to encourage participation in MSSP by those with the greatest potential to improve care and generate savings, achieving net program savings requires CMS to not only improve incentives to encourage participation but also to mitigate incentives for selection and coding (i.e., to reduce the subsidization of activities that have no evidence of improving care delivery).

Reducing these subsidies (by eliminating the regional adjustment, for example) would require CMS to phase-in alternative incentives if the agency wants continued participation from many current ACOs. However, the current path of layering on additional policies (e.g., prior-savings adjustment, prospective trend factor, capping the growth of regional risk scores) without phasing out any existing policies (e.g., regional adjustment, regional growth update factor, ACO coding allowance of 3 percent) avoids addressing fundamental flaws in the program's design and unnecessarily increases its complexity. The Commission urges CMS to:

- Mitigate the favorable selection by phasing out the regional adjustment. Including both the prior-savings adjustment and the regional adjustment maintains undesirable participation incentives and distorts the calculation of the prior-savings adjustment.
- Address the underlying coding incentives by adopting the Commission's prior recommendations to calibrate the HCC model using two years of data, remove codes generated from health risk assessments (including annual wellness visits) from risk score

²³ Medicare Payment Advisory Commission. 2022. Comment letter on the Centers for Medicare & Medicaid Services' (CMS's) 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. September 2. https://www.medpac.gov/wp-content/uploads/2022/09/09022022_Part_B_2023_CMS1770P_MedPAC_COMMENT_v2_SEC.pdf

²⁴ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2022. 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. Proposed rule. *Federal Register* 87, no. 145 (July 29): 45860–46843.

calibration and calculation, and apply an overall adjustment that accounts for the remaining differences between ACOs and the national assignable population.

- Address the complexities of using an ACO's region in the benchmark update factor by phasing-out the regional update factor and evaluate replacing the national update factor with its Accountable Care Prospective Trend (ACPT) or another benchmark. The current three-way blend maintains an unnecessary amount of complexity with mixed incentives.

We also encourage CMS to conduct new impact evaluations of MSSP; current impact estimates are based on older studies using data from the early years of the MSSP, when the program design was considerably different. In addition, because MSSP shared savings payments are included in Medicare Advantage (MA) benchmarks, evaluations should include the impact on all Medicare payments—including MA.

Adjusting benchmarks for ACOs with relatively high spending by removing negative regional adjustments and accounting for an ACO's prior savings

Benchmark rebasing helps account for more recent changes in both the Medicare program and an ACO's population. However, when an ACO experiences efficiency gains, those gains become part of the ACO's baseline spending when its benchmark is rebased—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.

To begin to address this potential ratcheting effect, starting in CY 2023, CMS added a prior-savings adjustment to benchmarks. To account for prior shared savings payments, the adjustment is 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 is based on the three performance years immediately preceding the start of a new agreement period.

CMS's adjustment for prior savings differs depending on whether an ACO had a negative or positive regional adjustment to its benchmarks. For ACOs with a negative regional adjustment to benchmarks (i.e., had high spending relative to their region), CMS caps the negative regional adjustment at 1.5 percent of national per capita fee-for-service (FFS) expenditures for assignable beneficiaries (although the cap can be lower depending on the share of Medicaid-eligible beneficiaries assigned to the ACO and the ACO's risk score). In addition, CMS's adjustment for prior savings is added to the negative regional adjustment and potentially results in a positive adjustment to some ACOs' benchmarks but continues to result in a negative adjustment for others.

To encourage greater participation from 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), CMS proposes to remove the negative regional adjustment. For ACOs with a positive regional adjustment to benchmarks, CMS proposes to keep the cap on the regional adjustment at 5 percent. 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.

CMS seeks comment on the proposal to remove the negative regional adjustment. In addition, CMS seeks comment on potential changes to the 50 percent scaling factor used in determining the prior-savings adjustment, including whether ACOs in the ENHANCED track should receive a larger scaling factor (e.g., 75 percent). Further, CMS seeks comment on potential changes to the positive regional adjustment to reduce the possibility of inflating the benchmark while still mitigating potential ratchet effects on ACO benchmarks.

Comment

We agree with CMS that better incentives are needed to induce participation among providers that serve beneficiaries with relatively high spending. Specifically, we concur with CMS's proposal to remove the negative regional adjustment.

However, consistent with our comments on the CY 2023 proposed MSSP changes, we continue to urge CMS to use the prior-savings adjustment as a means to phase out the regional adjustment to an ACO's benchmark baseline expenditures. The regional adjustment has coincided with ACOs selectively including physician practices to participate in the ACO and contributes to higher benchmarks without necessarily demonstrating efficiency gains during an ACO's MSSP participation. We are increasingly concerned that risk adjustment does not adequately account for an ACO's regional efficiency. For example, the Commission recently examined the FFS spending of beneficiaries who later enrolled in an MA plan.²⁵ We found that beneficiaries who were favorable relative to their regional risk-standardized spending average remained favorable for the entire duration of their FFS enrollment—even if their continuous FFS enrollment spanned more than a decade. ACOs can create this favorable bias in regional benchmarks by being particularly selective about identifying physician practices that serve assignable beneficiaries with low risk-adjusted spending.

We urge CMS to not use participation in the ENHANCED track as the measure for increasing the 50 percent scaling factor used for calculating the prior-savings adjustment. Under current policy, doing so would potentially exacerbate the inflation of benchmarks due to the regional adjustment. For example, in 2022, nearly all ACOs in the ENHANCED track (96 percent) received a positive regional adjustment to their benchmarks.

As an alternative, CMS should consider eliminating the regional adjustment to benchmarks entirely—including any involvement in the prior-savings adjustment calculation—and scaling up the prior-savings factor (currently 50 percent for ACOs) based on an ACO's regional "efficiency." For example, an ACO that would have qualified for a 2 percent positive regional adjustment could receive a 60 percent factor to its prior-savings adjustment, while an ACO that would have qualified for a 5 percent positive regional adjustment could receive a 75 percent factor to its prior-savings adjustment. In this way, both inflation to benchmarks and ratchet effects would be mitigated because the regional adjustment would be removed from both the performance-year benchmarks and the prior-savings adjustment. At the same time, CMS could provide incentives for current ACO participants to remain in the program by scaling up the shared savings rates based on

²⁵ Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

regional “efficiency” and assuring protection from shared losses up to an amount equivalent to the current regional adjustment calculation.

Applying the 3 percent cap on risk scores to the regional growth in risk scores used for updating an ACO’s benchmark

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 FFS 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 for a given beneficiary is the sum of the identified coefficients. CMS currently uses one year of 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 accounts for changes in an ACO’s population by adjusting baseline expenditures in ACO benchmarks through separate spending and risk score adjustments for assigned beneficiaries in each enrollment type (end-stage renal disease (ESRD), disabled, aged/dual eligible, and 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 nonassignable 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. To guard against unwarranted growth in risk scores (that is, increases in risk scores that are unrelated to actual changes in a beneficiary’s severity of illness), increases in baseline expenditures in MSSP benchmarks that are due to risk score changes are subject to a cap of 3 percent (after accounting for changes to an ACO’s demographic risk score) for each performance year in each enrollment type.

After the end of a performance year, CMS trends forward the baseline calculation of an ACO’s benchmark to the ACO’s performance year by blending the actual growth rates in the ACO’s

regional per capita expenditures and national per capita expenditures.²⁶ 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 a lower weight on the regional component.

The regional component of the update factor is calculated as the ratio of the risk-standardized expenditures (i.e., average spending divided by average risk score) of an ACO's region during its performance year to the baseline regional risk-standardized expenditures in the ACO's region during its most recent baseline year. Thus, growth in regional risk scores in an ACO's performance year will lead to lower benchmark update factors. Some ACO stakeholders have expressed concerns that CMS does not uniformly apply the 3 percent cap on both an ACO's risk score growth and the regional risk score growth used for an ACO's benchmark update factor.

CMS proposes to balance the interests of ACOs with its concerns about coding intensity by capping the prospective HCC risk score growth in an ACO's region between the most recent baseline year and the performance year and increasing the cap based on the percentage of assignable beneficiaries an ACO serves in its region. Thus, the up-to-3 percent cap on the region's risk score growth would increase as an ACO's share of assignable beneficiaries in its region increases. CMS contends that this market share adjustment to the cap on regional risk score growth would help to mitigate the impact that an ACO's own coding initiatives have on risk score growth in the ACO's region.

CMS seeks comment on its proposal to cap regional risk score growth for the purpose of calculating an ACO's benchmark update factor.

Comment

Given that CMS has not proposed a plan to phase in an alternative approach for updating benchmarks (e.g., administrative update factors) or to address the underlying differences between ACOs' risk scores and the average risk score for the assignable population, CMS's proposal to cap regional risk score growth with an adjustment for an ACO's market share is a reasonable approach. CMS's proposal reasonably protects ACOs from coding that may be out of their control, depending on the ACOs' share of the market. However, this approach should be viewed as an interim step because it does not address the underlying issues with coding incentives and regional benchmarking.

As we discussed in our September 2022 comments on the 2023 PFS proposed rule, allowing a 3 percent increase in benchmarks due to an ACO's risk score growth (beyond demographic risk score increases and the risk score growth of the assignable population) stems from an expectation that an ACO's assigned population will 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, the evidence we have observed suggests that the ACO

²⁶ Starting in 2024, the update factor for benchmarks will be a three-way blend that includes a fixed projected growth rate that is determined at the beginning of an ACO's agreement period and will be weighted as one-third of the overall update.

population should not have faster risk score growth (and indeed perhaps should have slightly slower risk growth) relative to the national assignable population.²⁷ To more directly address the underlying incentives for coding intensity, we urge CMS to consider the Commission's March 2016 recommendation to use two years of diagnostic data for calibration of the risk score model and the Commission's 2017 recommendation to remove health risk assessments (including annual wellness visits) from the calibration of the model and the calculation of risk scores.^{28,29} Any remaining differences that increase benchmarks should be offset with a uniform coding adjustment across all ACOs that can be tiered by level of coding intensity (similar to an option the Commission discussed in its March 2017 report to the Congress). In addition, as discussed above, regional benchmarking—including update factors based on risk-standardized regional spending increases—requires an underlying assumption that an ACO's efficiency relative to its region can be measured through risk adjustment. However, evidence to date suggests that risk-adjusted differences within a region tend to persist based on the baseline patient population.^{30,31} Thus, in addition to directly addressing coding incentives, CMS should consider phasing out the weighting of the regional update factor and replacing it with an administrative growth factor.

Expanding the ACPT over time and addressing overall market-wide ratchet effects

In 2023, CMS finalized changes to the way growth rates used to update historical benchmarks will be calculated. Starting with agreement periods that begin on January 1, 2024, and subsequent years, CMS will incorporate a prospectively determined growth factor that reflects projected growth in total per capita Part A and Part B FFS spending. The growth factor, referred to by CMS as the Accountable Care Prospective Trend (ACPT), will be generated by the Office of the Actuary and account for one-third of the overall growth rate used to update benchmarks. The other two-

²⁷ For example, CMS has noted that higher spending populations are increasingly underrepresented in MSSP since the change to regionally adjusted benchmarks. 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 the non-ACO population has been slower than that of beneficiaries assigned to ACOs. As described in our September 2022 comment letter, our analyses comparing risk scores for ACO-assigned and assignable non-ACO beneficiaries in 2015, 2017, and 2019 found that the renormalized average risk score of beneficiaries assigned to an ACO increased despite no overall increases to the renormalized demographic risk scores of beneficiaries. 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. This strongly suggests that the increase in ACO risk scores has mainly resulted from their coding efforts. For more detail, please see our September 2022 comment letter on CMS's 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. (https://www.medpac.gov/wp-content/uploads/2022/09/09022022_Part_B_2023_CMS1770P_MedPAC_COMMENT_v2_SEC.pdf)

²⁸ Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

²⁹ Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

³⁰ Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

³¹ Lyu, P. F., M. E. Chernew, J. M. McWilliams. Benchmarking changes and selective participation in the Medicare Shared Savings Program. *Health Affairs* 42, no. 5 (May): 622–631.

thirds of the growth rate will be composed of a weighted two-way blend of realized changes in per capita FFS spending nationally and at the regional level. The two-way blend is weighted such that the national component represents the portion of each individual ACO's share of assignable beneficiaries in its regional service area.

Relying solely on realized spending in ACO benchmark update calculations results in a phenomenon known as the "ratchet effect." Updating benchmarks based on realized spending growth means that when an ACO slows spending growth, their benchmark calculation reflects this slower growth, effectively "ratcheting" down the benchmark. The lower benchmark makes it increasingly difficult for an ACO to achieve the necessary spending level that results in shared savings payments. Thus, the ratchet effect may reduce incentives for an ACO to reduce spending by providing care more efficiently and may even dampen incentives for providers to participate in the program. These concerns about the ratchet effect are what led CMS to use the prospectively determined ACPT as one-third of the benchmark growth rate starting in 2024.

In this proposed rule, CMS is seeking comment on replacing the national component of the two-way blend with the ACPT and scaling the weight given to the ACPT in a revised two-way blend (i.e., ACPT and regional) based on the collective market share of multiple ACOs within the ACO's regional service area. CMS is seeking comments on this approach as a way of continuing to reduce the ratchet effect on benchmarks by increasing the portion of the update that is insulated from realized changes in spending.

Comment

As we noted in our comment on the CY 2023 proposed rule, the Commission agrees with CMS's efforts to address the ratchet effect on ACO benchmarks and supports moving to further decouple benchmark updates from realized changes in spending. In our June 2022 report to the Congress, we expressed concerns that by incorporating realized changes in FFS spending into benchmark updates, 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 support the refinements to the three-way blended benchmark update being considered and encourage CMS to continue working toward broad implementation of administrative benchmarks.

However, we continue to have reservations regarding certain aspects of the methodology CMS plans to use to determine the ACPT. These include concerns that projections of spending from the Office of the Actuary have historically overestimated growth in per capita spending. Shared savings payments or other value-based performance payments made to ACOs or providers should be excluded from the baseline calculation of the ACPT. 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. The ACPT could be adjusted periodically if it underpredicts or overpredicts health care spending in a given year due to events that are difficult to forecast, such as a recession that leads to reduced health care utilization across all payers. It could

also be adjusted if policymakers wished to increase or decrease the amount of savings generated from MSSP.

Furthermore, incorporating the ACPT should coincide with phasing out the regional adjustment to baseline expenditures in an ACO's benchmark. If the intent of the ACPT is to reduce ratcheting effects to benchmarks (i.e., to leave an ACO's gross savings in its benchmarks), CMS's prior-savings adjustment and its regional adjustment represent duplicative methods.

Incorporating Medicare Advantage data into public reporting

CMS publishes performance measures and other information about clinicians on the Medicare Care Compare website. Later this year, CMS plans to add information about the frequency with which clinicians performed certain procedures to the Care Compare clinician profile pages. Those counts are to be based on Medicare FFS claims data and will not reflect procedures furnished to people enrolled in MA or other types of insurance. In this proposed rule, CMS is proposing to publicly report aggregated counts of procedures performed by providers based on MA encounter data in addition to Medicare FFS utilization data. CMS reports that adding MA utilization to the counts of procedures will reduce the number of clinicians with counts that are too low to be publicly reported.

Comment

The Commission supports CMS's proposal to use MA encounter data to identify and characterize which clinicians have experience performing procedures. As of 2023, more than half of eligible Medicare beneficiaries are enrolled in MA, with an even greater share enrolled in some local areas. Accordingly, it is reasonable to expect that a significant fraction of the procedures performed by some clinicians during a year will be furnished to MA-enrolled beneficiaries; it is beneficial, then, for such experience to be reflected in public data under certain circumstances.

Considering the limitations of the encounter data, however, we encourage CMS to publish the methodology used to calculate counts of procedures from the encounter data. We also suggest that CMS report FFS and MA utilization data in separate fields when preparing the Provider Data Catalog (PDC) utilization data files; this would be more transparent and would make the files more useful to beneficiaries and policymakers.

The Commission's prior work has shown that the encounter data are incomplete and that options for validating the data are limited—particularly for professional services and procedures, for which there are no analogous data sources with which to compare. MedPAC found that in 2019 some MA enrollees had inpatient, home health, and dialysis services reported in either the Medicare Provider Analysis and Review file, home health assessments, or risk adjustment indicator file, but those services were not reported in MA encounter data.³² Incomplete reporting should not preclude the use of MA encounter data for the proposed purpose of identifying which clinicians have

³² Medicare Payment Advisory Commission. 2022. Medicare Advantage encounter data. Presentation at the Commission's September public meeting. <https://www.medpac.gov/wp-content/uploads/2021/10/Encounter-data-MedPAC-01-Sept-2022.pdf>.

experience performing certain procedures, because it means that the data are unlikely to produce an overestimate of a clinician's experience with a given procedure.

In contrast, the existence of duplicate records in the encounter data would pose the risk of overstating a clinician's level of experience with a given procedure. Both MedPAC and the CMS Office of Enterprise Data and Analytics (OEDA) have found that the encounter data contain duplicate service records. For example, OEDA found that the MA inpatient hospital encounters contain several thousand cases in which multiple encounters had the same beneficiary identification number, bill type, and start and end dates, but different organizational National Provider Identifiers (NPIs).³³ If such records actually reflect a single encounter between a beneficiary and a clinician, failing to remove the duplicate observations could lead to an overestimate of how frequently a service was provided. It is therefore important that CMS clarify the steps taken to ensure that procedures are not counted more than once.

In addition to considerations of how to identify the correct number of procedures, we suggest that CMS specify how procedures will be attributed to clinicians. The encounter data include multiple fields in which an NPI can be reported, and many encounters have multiple NPIs listed. In MedPAC's preliminary analysis of the encounter data physician file, we found that the NPI of the rendering physician is frequently missing and the NPI of the billing entity is generally populated with an organizational NPI rather than the NPI for an individual clinician. CMS should elaborate on how such information will be used to identify which clinician performed a procedure.

Given the data considerations described above, we recommend that the documentation address: 1) which encounter data files were used to identify procedures (e.g., physician, outpatient, inpatient, etc.); 2) how procedures were attributed to individual clinicians (including whether any edits or data-cleaning procedures were applied to the NPI field); and 3) what deduplication procedures were applied to the data.

Furthermore, we encourage CMS to report FFS and MA utilization data in separate fields when both fields have a sufficient number to be publicly reported in the Provider Data Catalog (PDC) Utilization Data files. In instances where either the FFS or MA procedure counts would be subject to CMS's small cell size policy, the data could be reported in a column containing the sum of the FFS and MA counts. Reporting the data in this manner will be more transparent—enabling users to choose the data they need while also maintaining the agency's standards for confidentiality.

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

³³ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023. *Medicare Advantage encounter data: Institutional providers analytic approach*. Baltimore, MD: CMS.
https://download.cms.gov/encounter_data/medicare%20advantage%20encounter%20data%20analytical%20methods_508.pdf.

Chiquita Brooks-LaSure
Administrator
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continuing this relationship. If you have any questions regarding our comments, please do not hesitate to contact Paul Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

A handwritten signature in black ink, appearing to read "m. chernew", with a horizontal line extending to the right from the end of the signature.

Michael E. Chernew, Ph.D.
Chair