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Economic Studies

Center for Health Policy

October 12, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1701-P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations--Pathways to Success [CMS-1701-P]

Dear Administrator Verma:

I welcome the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) "Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations--Pathways to Success" notice of proposed rulemaking. This letter comments on several different aspects of the proposed rule, primarily proposals to reconfigure participation options in the Medicare Shared Savings Program (MSSP) and proposals to change the benchmark methodology.

My main recommendations on each of these portions of the proposed rule are as follows:

- **Curtailing One-Sided Participation Options:** The requirement that all ACOs quickly accept two-sided risk could improve the performance of ACOs that continue to participate in the MSSP, but would also reduce MSSP participation. CMS' proposal does not strike an obviously unreasonable balance between these competing considerations, but there is real uncertainty about the correct policy path. Thus, if CMS finalizes this proposal, CMS should carefully monitor MSSP participation and change course if participation falls precipitously. Regardless, CMS should correct its claim that participation in MSSP via one-sided models has increased Medicare spending to date, which contradicts the best evidence.

- **Shifting to Five-Year Agreement Periods:** Shifting to five-year agreement periods would strengthen ACOs' incentives to reduce spending by breaking the link between ACOs' performance in the first two years of each agreement period and their future benchmarks. CMS should finalize this proposal. To align with this change, CMS should begin using five-year spending averages rather than three-year spending averages when establishing

ACOs' benchmarks. While this modification would worsen incentives during the first two years of each agreement period, it would improve them during the final three years of an agreement period. On average over the entirety of a five-year agreement period, this modification to CMS' proposal would likely improve incentives modestly.

- **Changing the Method of Measuring ACOs' Total Revenue:** CMS' proposal to measure ACOs' total Part A and B revenue based solely ACOs' participant lists, rather than also counting revenue received by providers with an ownership or operational interest in one or more ACO participants, could allow ACOs that are affiliated with a hospital to access participation options that are intended for physician-only ACOs. Thus, if CMS is going to vary the rules that apply to ACOs based on their total Part A and B revenue, it should count revenue received by the broader set of providers.

- **Modifying the Risk Adjustment Methodology:** CMS' proposal to rely solely on changes in CMS-HCC risk scores for the purposes of risk adjustment during an agreement period has the potential to simplify and improve risk adjustment in MSSP. However, CMS' proposal to limit benchmark adjustments to 3 percent in either direction is flawed. At a minimum, CMS should eliminate the limit on downward benchmark adjustments in order to deter risk selection by ACOs. CMS should also eliminate the limit on upward adjustments, which undermines risk adjustment's ability to protect ACOs from idiosyncratic deterioration in patient mix, and instead implement other policies that limit ACOs' ability to benefit from aggressive coding of patient diagnoses.

- **Capping and Shrinking the Regional Adjustment to ACO Benchmarks:** CMS' proposal to reduce the size of the regional adjustment would likely increase participation in the MSSP by ACOs with high spending relative to their regions, but would weaken participating ACOs' incentives to reduce spending by strengthening the link between ACOs' current performance and their future benchmarks. The analysis CMS uses to justify this proposal ignores the downsides of this policy change, so CMS should conduct additional analysis that takes account of these negative effects and reconsider its proposal based on the outcome of that analysis. CMS should also consider alternative changes to the benchmarking methodology that could encourage participation by historically high spending ACOs without undermining ACOs' incentives to reduce spending.

- **Implementing a National-Regional Blend for Calculating Trend Factors:** Rather than adopting benchmark trend factors based on blend of national and regional spending growth rates, CMS should continue to use purely regional trend factors, but exclude an ACO's own beneficiaries when computing the trend factors that apply to that ACO. When an ACO's service area does not include enough enrollees not aligned with the ACO to compute reliable trend factors, CMS should include data from adjacent or otherwise similar counties. CMS should also exclude an ACO's own beneficiaries when computing the regional spending average used in computing the regional adjustment.

- **Using Regional Factors During an ACO's First Agreement Period:** CMS should finalize its proposal to use regional trend factors when establishing and updating an ACO's benchmark during its first agreement period. CMS should also finalize its proposal to apply

a regional adjustment when establishing an ACO's benchmark for a first agreement period, but it should conduct additional analysis to determine the size of that adjustment.

The remainder of this letter discusses my comments on each of these portions of the rule in greater detail. Please note that the views expressed in this letter are my own and do not necessarily reflect the views of officers, trustees, or other staff members of the Brookings Institution.

Curtailing One-Sided MSSP Participation Options
(Section II.A.3 of the NPRM)

The proposed rule would reconfigure providers' options for participating in the MSSP, replacing the existing MSSP Tracks 1, 2, and 3, as well as the Center for Medicare and Medicaid Innovation (CMMI) Track 1+ model, with BASIC and ENHANCED tracks within the MSSP. Most consequentially, these changes would sharply curtail ACOs' ability to participate in the MSSP under models that require only one-sided risk. Currently, ACOs can participate under one-sided risk for up to six years via the Track 1 model. Under the proposed rule, ACOs could participate under one-sided risk for at most two years via the proposed BASIC track. After that two-year period, an ACO would have to participate in a "level" of the BASIC track that includes downside risk similar to that under the current Track 1+ model, or in the ENHANCED track, which is essentially the same as the current Track 3.

Requiring ACOs to bear two-sided risk has both advantages and disadvantages, and there is real uncertainty about how to weigh these competing considerations. There are two main benefits to consider. First, requiring two-sided risk strengthens ACOs' incentives to reduce spending. Under one-sided risk, reducing spending only generates financial rewards for the ACO if the ACO's spending comes in at a level that makes the ACO eligible for shared savings. But because spending outcomes have a significant random component even effective ACOs will sometimes be ineligible for shared savings. Under two-sided risk, reducing spending can pay off for the ACO even if the ACO's spending exceeds its benchmark by reducing the ACO's shared loss payments. Second, ACOs' shared loss payments directly benefit the federal budget. Both of these benefits are plausibly significant, although the importance of the first is hard to quantify with existing evidence.

On the other hand, requiring ACOs to bear downside risk will cause some ACOs that would have participated in the MSSP under one-sided risk to leave the program. ACOs that currently have spending above the average in their region would be particularly likely to depart because ACO benchmarks are based in part on regional average spending; for these ACOs, the expected cost of making shared loss payments would tend to exceed the expected benefit of receiving shared savings payments. Other ACOs might lack the capital required to make a significant shared loss payment and thus decline to participate, even if they thought they were much more likely to receive a shared savings payment than to be required to make a shared loss payment.

At various points in the proposed rule, CMS suggests that losing ACOs that currently participate in MSSP via Track 1 would not be cause for concern. In particular, CMS cites an analysis that compares Track 1 ACOs' actual spending to their benchmarks to argue that Track 1 ACOs'

participation in MSSP actually *increased* federal spending on net in 2016. If that were the case, then losing these providers from the MSSP might indeed be a benign outcome.[1]

However, CMS' analysis is misleading. As other analysts have emphasized, ACOs' benchmarks are set based on policy considerations and do not measure what ACOs would have spent in the absence of the MSSP, so they cannot be used to gauge the causal effect of the MSSP on Medicare spending.[2] Consistent with this, research that compares ACOs' spending to true counterfactuals found that the MSSP reduced federal spending in 2015, despite the fact that the vast majority of MSSP ACOs in 2015 were participating through Track 1.[3] That research found that ACO performance was either stable or improving over time, so it is plausible that a similar analysis for 2016 would find similar or better results. Simply comparing ACOs' actual spending to their benchmarks also does not capture "spillover" effects ACOs may have on beneficiaries that are not assigned to the ACO; notably, CMS' own regulatory impact analysis concludes that these spillover effects have been substantial, and, on this basis, concludes that the MSSP generated large net savings for the Medicare program in 2016. Thus, the best evidence implies that losing a significant number of ACOs that currently participate in the MSSP via Track 1 would have real costs

It is uncertain how much eliminating Track 1 would reduce participation in the MSSP. Track 1 currently accounts for more than three-quarters of aligned beneficiaries associated with ACOs participating in the MSSP or Track 1+. It is doubtful that all of these ACOs would leave the program if required to take on two-sided risk. Some would ultimately have transitioned to two-sided risk on their own as they gained experience with MSSP and gained greater familiarity with the bonus payments available under the Quality Payment Program. Additionally, if two-sided risk became a required feature of MSSP participation, new structures to help providers bear that risk would likely emerge. For example, ACOs commonly participate in the MSSP in collaboration with a third-party service provider; these service providers may be able to bear a portion of this risk on ACOs' behalf if necessary. Nevertheless, as CMS' regulatory impact analysis recognizes, requiring two-sided risk will likely cause some meaningful reduction in MSSP participation.

Given the paucity of evidence on how ACOs would behave under different policy regimes, it is hard to definitively weigh the benefits of improved incentives for MSSP participants against the costs in the form of reduced MSSP participation. CMS' proposals not do strike on obviously unreasonable balance between these competing considerations, but in light of the uncertainty, there is a real risk that this policy will not operate as intended. Thus, CMS should carefully monitor how the policy affects participation in MSSP and swiftly modify the policy if participation falls sharply.

Summary of Recommendations: CMS' proposals to require providers to take on two-sided risk do not strike an obviously unreasonable balance among competing objectives, but there is real uncertainty about the appropriate policy path. CMS should carefully monitor how this policy

[1] Even if CMS' analysis were correct, reductions in participation might still be cause for concern. The MSSP has objectives other than reducing federal spending, like improving the quality of care. Additionally, even if Track 1 ACOs cost the federal government money in the aggregate, if some Track 1 ACOs did generate savings for the federal government, then it still would be preferable to keep those ACOs in the program.

[2] Chernew, Michael E., Christopher Barbery, and J. Michael McWilliams. 2017. "Savings Reported by CMS Do Not Measure True ACO Savings." Health Affairs Blog. doi: 10.1377/hblog20170619.060649.

[3] McWilliams, J. Michael. 2018 "Medicare Spending after 3 Years of the Medicare Shared Savings Program." *New England Journal of Medicine*. 379(12): 113-1149. doi: 10.1056/NEJMsa1803388.

change affects participation in MSSP and change course if necessary. CMS should correct its claim that participation in MSSP via one-sided models has increased Medicare spending to date.

Shifting to Five-Year Agreement Periods
(Section II.A.2 of the NPRM)

The proposed rule would lengthen ACO agreement periods to five years, up from three years under current regulations. This proposal would likely strengthen ACOs' incentives to reduce spending. As discussed in detail later in this comment letter, the benchmark rebasing that occurs at the start of each new agreement period can undermine ACOs' incentives to reduce spending because rebased benchmarks are based in part on ACOs' own recent spending. As a result, ACOs that reduce spending today are "penalized" with lower benchmarks in the future.

Shifting to five-year agreement periods eliminates this problem for the first two years of each agreement period because rebasing calculations only use the most recent three years of spending data. For this reason, the proposal would be an improvement over the status quo. However, if the shift to five-year agreement periods is finalized, CMS should consider changing rebasing calculations to use five-year spending averages rather than the three-year spending averages currently used. This would reintroduce the incentive problem described above during the first two years of an ACO's agreement period, but ameliorate the problem during the final three years of an agreement period. On average over the entirety of a five-year agreement period, this modification to CMS' proposal would likely improve incentives modestly.

Summary of Recommendations: CMS should finalize its proposal to lengthen ACO agreement periods to five years. To align with this change, CMS should begin using five-year spending averages rather than three-year spending averages in rebasing calculations.

Changing the Method of Measuring an ACOs' Total Revenue
(Section II.A.3 and Section II.A.5 of the NPRM)

CMS proposes to vary its treatment of ACOs based on their total revenue under Medicare Parts A and B. ACOs whose total Part A and B revenue is less than 25 percent of total spending by their assigned beneficiaries would be allowed to participate in the BASIC track for a longer period. Additionally, shared losses paid by ACOs participating in the BASIC track would be limited to no more than 8 percent of total Part A and B revenue. CMS' objective in configuring the program in this way is to provide more lenient terms to ACOs that do not include a hospital.

CMS proposes to define an ACO's total Part A and B revenue as the total Part A and B revenue received by the ACO's participants. This definition departs significantly from the definition used in the Track 1+ model, under which CMS also counted Part A and B revenue received by providers with an ownership or operational interest in one or more ACO participants.

CMS' proposed approach has a serious shortcoming. Failing to count revenue earned by entities with an ownership relationship to ACO participants would allow many ACOs that are affiliated with a hospital to access participation options that are intended for physician-only ACOs. Consider, for example, an ACO that consists of a hospital and a set of hospital-owned physician practices. Under CMS' proposed approach, the ACO could list the physician practices as ACO

participants, but not list the hospital. This would greatly reduce the ACO's measured Part A and B revenue, allowing it to participate in the MSSP while bearing much less financial risk.

Citing experience under Track 1+, CMS argues that counting revenue earned by entities with an ownership or operational interest in ACO participants would not appreciably change an ACO's measured Part A and B revenue in most cases. But the Track 1+ evidence cannot speak to the key policy question. Precisely because Track 1+ counts revenue earned by providers with an ownership or operational interest in an ACO participant, there was no incentive to strategically exclude these providers from an ACO's participant list. Experience under Track 1+ is therefore uninformative regarding the potential importance of this type of strategic behavior.

Summary of Recommendations: If CMS is going to vary the rules that apply to ACOs based on their total Part A and B revenue, it should count revenue received by entities that have ownership and operational interests in ACO participants, not just revenue received by providers on an ACO's participant list.

Modifying the Risk Adjustment Methodology Used During an Agreement Period (Section II.D.2 of the NPRM)

CMS currently uses a relatively complex method to adjust an ACO's benchmark for changes in the risk profile of its beneficiaries since the start of an agreement period. For newly aligned beneficiaries, CMS uses CMS-HCC risk scores to adjust for changes in risk mix. For beneficiaries continuously aligned with an ACO since the start of an agreement period, CMS adjusts their contribution to the benchmark for demographic changes and makes a downward adjustment if these beneficiaries' risk scores decline, but makes no corresponding adjustment if risk scores rise. The proposed rule would eliminate the distinction between continuously and newly aligned beneficiaries and instead adjust an ACO's benchmark based on the full change in the average CMS-HCC risk score of the ACO's beneficiaries, except that the total adjustment to the ACO's benchmark would be limited to a maximum of 3 percent in either direction.

The revised methodology has two virtues; it is simpler than the old methodology, and it better protects ACOs against deteriorations in their patient mix. However, CMS' proposal to cap risk-score-based adjustments at 3 percent in either direction is problematic. Most importantly, the limit on downward adjustments will encourage ACOs to avoid sicker enrollees and seek out healthier enrollees since, once an ACO's risk score has declined by at least 3 percent, risk adjustment will no longer offset the benefits of risk selection to the ACO. At a minimum, therefore, CMS should eliminate the cap on downward adjustments in ACOs' risk scores.

On the other end of the spectrum, capping upward adjustments limits risk adjustment's ability to compensate ACOs for random changes in their patient mix. This reduces the predictability of ACOs' financial performance and thereby makes MSSP participation less attractive. CMS is correct to worry that allowing unlimited upward adjustments could allow ACOs to profitably increase coding intensity. However, strong incentives to increase coding intensity already exist since CMS already fully incorporates an ACO's risk score when setting an ACO's benchmark at the start of an agreement period. Moreover, there are better ways of addressing coding concerns. In particular, CMS could implement a coding intensity adjustment like the one used in Medicare

Advantage, create audit mechanisms to detect inappropriate coding, and introduce harsher penalties for ACOs found to have engaged in inappropriate coding.

Summary of Recommendations: CMS should finalize its proposals to update benchmarks based on changes in CMS-HCC risk scores. However, CMS should not finalize the proposed cap on risk-score-based adjustments. At a minimum, CMS should eliminate the cap on downward adjustments in order to deter risk selection by ACOs. CMS should also eliminate the cap on upward adjustments and implement other policies aimed at limiting ACOs' ability to benefit from aggressive coding.

Capping and Shrinking the Regional Adjustment to ACO Benchmarks (Section II.D.3.c of the NPRM)

To establish an ACO's benchmark for its second and subsequent agreement periods, CMS undertakes a two-step process: (1) CMS computes average spending by the ACO's beneficiaries during the three years immediately preceding the agreement period; and (2) it adds a "regional adjustment" equal to percentage of the difference between regional average spending and the ACO's own historical spending. The percentage used in computing the regional adjustment depends on how long the ACO has been participating in the program and how the ACO's spending compares to average spending in its region. Under this approach, each ACO's benchmark is effectively a weighted average of spending by the ACO's assigned beneficiaries and average spending in the ACO's region during the years before each agreement period.

CMS proposes to reduce the size of the regional adjustment in two ways. First and likely most importantly, CMS proposes to limit the total size of the regional adjustment to 5 percent of national average fee-for-service spending. Second, CMS proposes to make the underlying regional adjustment a smaller percentage of the difference between regional average spending and the ACO's own historical spending in the long run, reducing the relevant percentage from 70 percent to 50 percent. (CMS' proposal would have more complicated effects in the short and medium run. CMS' proposal to apply a regional adjustment for ACOs' first agreement period, discussed in greater detail below, would increase the weight placed on regional spending in some cases.)

Evaluating these proposed changes is challenging because determining the appropriate size of the regional adjustment requires trading off various competing considerations. On the positive side, a larger regional adjustment strengthens participating ACOs' incentives to make care more efficient. This is because the regional adjustment weakens the link between an ACO's future benchmarks and its own past spending, which reduces the extent to which lowering spending today reduces the ACO's future benchmarks. Additionally, the regional adjustment increases the expected reward to attracting an additional beneficiary for low-spending ACOs and reduces it for high-spending ACOs, which may encourage more efficient providers to expand their market share, while discouraging less efficient providers from doing so.

On the other hand, it is also important to consider how the regional adjustment affects incentives for MSSP participation by different types of ACOs, as well as the attendant implications for Medicare spending. A modest regional adjustment can actually improve participation incentives because it accounts for the tendency of ACOs that were low-spending in prior periods to experience somewhat faster growth in subsequent years (and vice versa), a phenomenon known as

“mean reversion.”[4] Due to mean reversion, basing benchmarks solely on an ACO’s own recent spending will tend to give historically high-spending ACOs benchmarks that are higher than needed to get them to participate in the program, providing them with an unnecessary windfall at, while giving historically low-spending ACOs benchmarks that may be too low to get them to participate, forfeiting the opportunity to improve the efficiency of those providers’ care.

However, a regional adjustment that goes beyond what is needed to account for mean revision—which the existing adjustment almost certainly does—creates the opposite problem. A large regional adjustment makes MSSP participation less attractive for historically high-spending ACOs, potentially forfeiting the opportunity to improve the performance of those relatively inefficient providers. At the same time, a regional adjustment beyond what is needed to account for mean reversion will provide windfall benefits to historically low-spending ACOs.[5]

It is possible that CMS’ proposed approach strikes a better balance among these competing considerations than the current approach. However, CMS’ analysis provides little reason to be confident that this is the case. CMS’ qualitative discussion of the proposed changes essentially ignores the concern that reducing the size of the regional adjustment could weaken participating ACO’s incentive to reduce spending or discourage expansion by low-spending ACOs. Similarly, the regulatory impact analysis, which is the main evidence CMS provides in favor of making this change, appears to assume that reducing the size of the regional adjustment would have *no* effect on performance by participating ACOs. This assumption is implausible and is likely to lead CMS to understate the appropriate size of the regional adjustment. CMS should remedy these flaws in its analysis and, if merited, modify its proposals accordingly.

It is feasible to modify CMS’ analysis to account for how the regional adjustment affects ACOs’ marginal incentives to reduce spending. Specifically, CMS could estimate how the present value of the ACO’s expected shared savings (or shared losses) change when the ACO reduces spending by a dollar—incorporating both the contemporaneous increase in shared savings (or reduction in shared losses) *and* the reduction in future shared savings (or increase in shared losses) due to lower benchmarks—and examine how this marginal return varies across benchmarking methodologies. These marginal returns could be estimated under varying assumptions about how much ACOs discount future cash flows. CMS could then adjust the amount ACOs are expected to reduce spending under different policy scenarios based on the differences in this marginal return across benchmarking methodologies. A reasonable baseline assumption is that the amount ACOs will reduce spending is roughly proportional to the expected marginal return to reducing spending, but CMS should examine alternative assumptions as well.

Economic theory and the available evidence provide less guidance on how to account for the possibility that the regional adjustment might promote expansion by more efficient ACOs. However, this is not a justification for simply assuming that these effects do not exist. In light of

[4] This phenomenon reflects that fact that high spending in any particular period typically reflects a combination of persistent factors, like inefficient care patterns and patient population differences, and transient “bad luck,” like an idiosyncratic expensive case.

[5] Selective participation is mitigated to some degree by the bonus for participation in advanced alternative payment models under the Quality Payment Program, but that bonus would have to be much larger to eliminate these concerns entirely.

the substantial uncertainty, CMS could conduct analyses under a range of assumptions about how changes in an ACO's expected shared savings affect its market share.

Stepping beyond the current proposal, CMS should consider alternative modifications to the benchmarking methodology that could ameliorate the main downsides of the existing regional adjustment (specifically, reduced participation by high-spending ACOs) without undermining ACOs' incentives to reduce spending. Namely, CMS could construct all or part of an ACO's benchmark by trending forward the ACO's benchmark from its first agreement period using some growth rate unrelated to the ACO's own performance; Michael McWilliams, Michael Chernew, and Bruce Landon propose this approach in their comment letter on this proposed rule.[6] Like the regional adjustment, this approach would break the link between an ACOs' current performance and its future benchmarks, thereby ensuring ACOs have strong incentives to reduce spending. However, it would offer higher benchmarks to historically high spending ACOs than the existing regional adjustment methodology, thereby encouraging those ACOs to participate in the MSSP, while limiting windfalls to historically low spending ACOs.

An ideal approach would likely combine the existing benchmarking approach with the approach proposed by McWilliams, Chernew, and Landon. Specifically, a portion of an ACO's benchmark would be set by trending forward the ACO's benchmark from is first agreement period, and a portion would be set based on average spending in the ACOs' region. The weight placed on regional average spending would be based on: (1) the amount the ACO's spending is expected to have reverted toward the mean since the benchmark period associated with the ACO's first agreement period; (2) the extent to which historically high-spending ACOs are expected to be more successful in reducing spending than low-spending ACOs; and (3) an additional amount to encourage historically low-spending ACOs to expand to serve additional patients. Because the expected amount of mean reversion is likely to rise over time, the appropriate weight on the regional average component would likely rise over time as well. If desired, some weight could also be placed on a traditional rebased benchmark in the long run. The appropriate weight on the traditional rebased benchmark would depend on the appropriate balance between ensuring strong incentives at the margin and ensuring broad participation by ACOs at different spending levels.

CMS considered approaches similar to those proposed by McWilliams, Chernew, and Landon in the rulemaking establishing the current benchmarking methodology, but rejected them.[7] CMS expressed concern about locking in historical spending differences for the indefinite future, as well as concerns regarding how to adjust for changes in ACO composition over time. The latter concern can be addressed by rebalancing the weight between the trended component of the benchmark and the regional average component of the benchmark over time, as suggested above. Additionally, the comment letter by McWilliams, Chernew, and Landon describes methods for addressing changes in ACO composition that should be sufficient to largely address these concerns.

<u>Summary of Recommendations</u>: CMS should redo its analysis of these proposed changes to account for main downsides of curtailing the regional adjustment, notably weakening incentives for ACOs to reduce spending and discouraging efficient ACOs from expanding. Based on the

[6] The comment by McWilliams, Chernew, and Landon is available at https://hmrlab.hcp.med.harvard.edu/files/hmrtest2/files/comment_on_mssp_proposed_rule_cms-1701-p_-_mcwilliams_chernew_landon_01.pdf.

[7] 81 CFR 38011

results from that improved analysis, CMS should reconsider whether its proposed changes appropriately balance the competing objectives of the regional adjustment. CMS should also consider alternative changes to the benchmarking methodology that could encourage participation by historically high-spending ACOs without undermining incentives to reduce spending.

Implementing a National-Regional Blend for Calculating Trend Factors (Section II.D.3.d of the NPRM)

CMS generally uses regional spending growth rates to derive the trend factors used in two parts of the benchmarking calculations: combining data from the three years of the benchmark period and trending the benchmark forward to each performance period.[8] Regional trend factors have important advantages relative to the national trend factors CMS has used in the past since they account for region-specific changes in practice patterns, socioeconomic factors, and other variables that may influence an ACO's spending performance. This reduces the amount of "noise" in ACOs' measured performance, which may make MSSP participation more attractive. It also makes MSSP participation more attractive to ACOs in regions where spending growth is expected to exceed national spending growth, while curtailing windfalls to ACOs in regions where spending growth is expected to be slower than national spending growth.

However, as CMS notes in the proposed rule, in instances where an ACO accounts for a large fraction of all Medicare beneficiaries in its region, an ACO's own performance can have an excessive influence on the regional trend factors. This fact can, in turn, substantially weaken an ACO's incentive to reduce spending because an ACO's success in reducing spending translates into a lower regional trend factor and, thus, a lower benchmark, thereby keeping the ACO from getting full credit for the savings it achieved. For example, for an ACO that accounted for 40 percent of the beneficiaries in its region, reducing spending by a dollar will reduce the ACO's benchmark by around 40 cents, so the ACO will only receive credit for 60 cents of savings. CMS proposes to address this problem by using trend factors based on a blend of national and regional growth rates, with the ACO's weighted average penetration in its service area determining the weight placed on the national growth rates.

CMS' proposed approach would likely be an improvement over current practice, but CMS' proposed approach nevertheless has two key flaws. First, CMS' proposed approach only partially solves the problem at hand. Consider once again an ACO that accounts for 40 percent of the beneficiaries in its region. Under CMS' proposal, national growth rates will receive a weight of only 40 percent in computing the ACO's trend factor, so the ACO's own performance will still determine around 24 percent (=0.6 x 0.4) of the blended trend factor. As a result, if the ACO reduces spending by a dollar, its benchmark will fall by around 24 cents, and it will receive credit for only around 76 cents of savings. Thus, while CMS' proposed approach is an improvement relative to using the existing regional trend factors, much of the incentive problem remains. Second, placing significant weight on national growth rates would result in a trend factor that does a worse job capturing the local spending trends facing an ACO. Indeed, as noted above, the original reason for adopting regional trend factors was to better capture these local trends.

[8] The exception is an ACO's first agreement period, when CMS currently uses national trend factors. However, as discussed below, CMS is proposing to switch to regional trend factors in this rule.

In light of these shortcomings, a better approach would be to exclude each ACO's own beneficiaries when computing regional trend factors. This approach would entirely eliminate the ACO's influence on its own trend factor. This approach would also completely (or almost completely) preserve the benefits of using regional trend factors in benchmarking calculations.

The proposed rule cites three reasons for rejecting this alternative approach, but each of CMS' concerns is either readily addressed or misplaced. First, CMS argues that the number of enrollees in an ACO's service area that are not affiliated with the ACO may sometimes be too small to estimate a reliable trend factor; however, this problem can be easily addressed by incorporating information from adjacent or similar counties when population sizes are too small. Second, CMS argues that beneficiaries not affiliated with the ACO may differ from those who are affiliated with the ACO; however, this problem affects virtually any conceivable trend methodology, including CMS' proposed national-regional blend, so it does not provide a basis for rejecting this methodology in particular. Third, CMS argues that ACOs may try to attract healthier enrollees and drive away sicker enrollees in order to manipulate the trend factor; however, these types of risk selection incentives are inherent in the ACO program and, as in other settings, the best policy response is to operate an effective risk adjustment program.

As a final note, while CMS' proposal focuses on how an ACO's performance affects the trend factors used *during* an agreement period, an ACO's own performance also affects the regional spending average used to compute the regional adjustment to its benchmark for *future* agreement periods. Including the ACO's own beneficiaries in the regional average used to compute the regional adjustment undermines one of the main objectives of the regional adjustment, which is to (partially) break the link between the ACO's current performance and its future benchmarks. For this reason, CMS should also exclude an ACO's own beneficiaries from the regional spending average used to compute the regional adjustment at the start of an agreement period.

<u>Summary of Recommendations</u>: Rather than adopting trend factors based on a national-regional blend, CMS should continue to use purely regional trend factors, but exclude an ACO's own beneficiaries when computing those trend factors. In cases where an ACO's service area does not include enough enrollees not aligned with the ACO to compute reliable trend factors, CMS should include data from adjacent or otherwise similar counties. CMS should also exclude an ACO's own beneficiaries when computing the regional spending average used to compute the regional adjustment to an ACO's benchmark at the start of an agreement period.

Using Regional Factors During an ACO's First Agreement Period (Section II.D.3.b of the NPRM)

As described above, after an ACO's first agreement period, CMS uses regional trend factors to combine data from the benchmark years and to update the ACO's benchmark during an agreement period, and CMS implements a regional adjustment when establishing an ACO's benchmark. In contrast, CMS currently uses national trend factors and does not make a regional adjustment in benchmark calculations for an ACO's first agreement period. In this proposed rule, CMS proposes to begin using regional trend factors and making a regional adjustment in benchmark calculations for an ACO's first agreement period.

CMS' proposal to adopt regional trend factors during an ACO's first agreement periods is a good one. The advantages of using regional trend factors discussed above apply just as strongly to first agreement periods as to subsequent agreement periods. Using the same trend factors across all agreement periods will also simplify the benchmarking methodology, as CMS notes.

CMS' proposal to implement a regional adjustment during an ACO's first agreement period also has merit, but CMS should do additional analysis to determine the appropriate size of the adjustment. The rationale for implementing a regional adjustment is markedly different in an ACO's first agreement period than in later agreement periods. In particular, as discussed above, the most important rationale for a regional adjustment in later agreement periods is to reduce the link between an ACO's current performance and its future benchmarks, thereby strengthening the ACO's incentive to reduce spending. That rationale is not relevant to an ACO's first agreement period (unless the behavior of non-ACO providers is shaped by the possibility that they might choose to join an ACO in the future, which is likely not a significant issue in practice).

Rather, the most important rationale for a regional adjustment in an ACO's first agreement period is to account for mean reversion, the tendency of high-spending ACOs to experience below-average spending growth and low-spending ACOs to experience above-average spending growth in subsequent years. The appropriate weight to place on the regional adjustment in an ACO's initial agreement period thus should reflect the amount of mean reversion actually experienced by ACOs, plus possibly a modest additional amount to reflect the potential benefits of encouraging relatively low-spending ACOs to expand their market shares. CMS should do an analysis to estimate the amount of mean reversion in ACOs' spending and set the weight placed on the regional adjustment in a first agreement period accordingly.

Summary of Recommendations: CMS should finalize its proposal to use regional trend factors when establishing and updating an ACO's benchmark during its first agreement period. CMS should also finalize its proposal to apply a regional adjustment when establishing an ACO's benchmark for a first agreement period, but it should conduct additional analysis to determine the appropriate size of that regional adjustment.

Thank you for the opportunity to comment on CMS' proposed rule. I hope that these comments are helpful. If it would be helpful to discuss these comments further, I would be happy to do so.

Sincerely,

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