

# USC-BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POLICY

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September 8, 2022<sup>1</sup>

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services

**Re: 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 Medicaid 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 Medicare Program; Request for Information on Medicare [CMS–1770–P]**

Dear Administrator Brooks-LaSure:

I am writing in response to several proposals related to the Medicare Shared Savings Program (MSSP) that were included in a recent proposed rule issued by the Centers for Medicare and Medicaid Services (CMS).<sup>2</sup> I thank CMS for the opportunity to comment on these proposals, and I commend CMS on its efforts to ensure that MSSP accountable care organizations (ACOs) are a vehicle for improving the efficiency of care delivery in Medicare.

In brief, I comment on three of CMS' proposals related to the MSSP:

- *Limiting negative regional adjustments and adjusting benchmarks for prior savings:* CMS should proceed with its proposals to limit negative regional adjustments and adjust benchmarks for prior savings. These proposals would help ensure that high-cost providers have a path to participate in the MSSP without reintroducing strong “ratchet effects” that discourage participants from reducing spending. CMS should, however, consider modifying its proposed prior savings adjustment to ensure that these adjustments do not “fade out” too quickly over time. Moreover, relying on a prior savings adjustment does have important limitations. Thus, over the longer-term, CMS and Congress should strengthen the negative financial consequences for providers that opt out of the MSSP, which would reduce concerns about selective participation and allow CMS to return to a benchmark methodology more like its current one.
- *Using a prospective external factor to update the historical benchmark:* CMS should abandon its proposal to use projected spending growth, rather than just realized spending growth, to update ACO benchmarks within an agreement period. Due to the likelihood of substantial projection errors, this approach would expose ACOs to considerable financial risk and, in expectation, create significant fiscal costs for the federal government. Alternative approaches, like using larger geographic regions to compute the regional

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<sup>1</sup> The version of this letter submitted to CMS was dated September 6, 2022. This version includes a revised discussion of how ACO coding efforts would affect Medicare spending on net (mostly in footnote 6) but reaches the same qualitative conclusions.

<sup>2</sup> Please note that the views expressed in this letter are my own and do not necessarily reflect the views of the Brookings Institution or anyone affiliated with the Brookings Institution other than myself.

component of the existing trend factor or updating benchmarks based on realized spending growth plus a fixed amount (e.g., 0.25 percentage points) could address CMS' concerns about how ACOs' efforts to reduce spending are affecting trend factors without introducing projection errors.

- *Modifying the risk adjustment 3% cap:* CMS should proceed with its proposal to relax the 3% limit on increases in ACO risk scores during an agreement period. If anything, CMS should consider going further. Risk adjustment discourages ACOs from trying to attract healthier enrollees and avoid sicker ones, and it encourages ACOs to participate in the MSSP by reducing financial uncertainty from fluctuations in patient mix. The cap on risk score increases, even in its modified form, makes the MSSP risk adjustment system less effective in achieving these goals. Furthermore, contrary to what CMS asserts in the proposed rule, ACO efforts to capture additional diagnoses may not increase federal costs, on net, after accounting for effects on payments to Medicare Advantage plans (although they still consume real resources).

The remainder of this letter discusses these three proposals in greater detail.

### **Limiting Negative Regional Adjustments and Adjusting Benchmarks for Prior Savings**

Under the original MSSP benchmark methodology, an ACO's benchmark for a given agreement period equaled the (trended) average spending of the ACO's patients over the 3 years prior to the agreement period. CMS has long recognized that this approach had serious shortcomings. In particular, if an ACO successfully reduced spending during a given agreement period, then it would face a lower benchmark in subsequent agreement periods. This "ratchet effect" dramatically reduced ACOs' incentives to reduce spending and, over time, could have resulted in benchmarks that were too low to allow ACOs to continue participating in the MSSP.

To address this problem, CMS modified the benchmark methodology in a rulemaking process that concluded in 2016. Under this approach, CMS makes a "regional adjustment" to an ACO's benchmark equal to a specified percentage of the difference between: (1) average spending in the ACO's region; and (2) the benchmark calculated under CMS' original methodology. The resulting benchmark is a weighted average of the ACO's benchmark under the original methodology and average spending in the ACO's region. Under current rules, the weight placed on regional average spending increases over time, reaching 50% for all ACOs in the long run.

These changes mitigated the ratchet effects embedded in the original benchmark methodology but, as CMS noted at the time, had the potential to create a new problem. Namely, ACOs with spending above the regional average face negative regional adjustments, which can cause them to opt out of the MSSP. On the other hand, ACOs with spending below the regional average receive positive regional adjustments, which cause them to remain in the program and receive substantial shared savings payments even if they fail to actually reduce spending. This pattern of selective participation generates direct fiscal costs for the federal government. It also makes it difficult to engage high-cost providers in the MSSP, which may substantially reduce the MSSP's effectiveness since there is some evidence that these providers have the greatest scope to reduce spending.<sup>3</sup>

The proposed rule makes a compelling case that selective participation has become a serious problem in the MSSP. Notably, CMS indicates that nearly 90% of ACOs now have spending below the regional average. This percentage would likely be above 50% even in the absence of selective participation since ACOs' efforts to reduce

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<sup>3</sup> J. Michael McWilliams et al., "Early Performance of Accountable Care Organizations in Medicare," *New England Journal of Medicine* 374, no. 24 (June 16, 2016): 2357–66, <https://doi.org/10.1056/NEJMsa1600142>.

spending likely push their spending somewhat below the average. Nevertheless, it is unlikely that this percentage would be as high as 90% without considerable selective participation.

The proposed rule puts forward two proposals aimed at addressing the selective participation problem that exists under the current methodology without reintroducing the severe ratchet effects that existed under the original methodology. First, to facilitate participation among high-cost ACOs, the proposed rule would limit the size of negative regional adjustments to at most 1.5% of national Part A and B spending—and less than that in many cases. Second, in an effort to avoid recreating the severe ratchet effects that existed under the original benchmark methodology, the proposed rule would introduce a “prior savings adjustment.” Under this approach, CMS would, in specified cases, increase an ACO’s benchmark by all or part of the difference between the ACO’s benchmark and its realized spending during the ACO’s preceding agreement period. Under the CMS proposal, a negative regional adjustment could generally be offset dollar-for-dollar by prior savings. Beyond that point, an ACO’s benchmark would be increased by 50% of the amount of prior savings (except that ACOs eligible for a positive regional adjustment would receive the larger of the prior savings adjustment or the positive regional adjustment).

This is a thoughtful and well-crafted set of proposals that would increase the attractiveness of MSSP participation for high-cost ACOs, while still limiting ratchet effects. The key virtue of the prior savings adjustment is that it allows CMS to “carry forward” information on an ACO’s pre-MSSP (or early-MSSP) spending and, thus, set persistently higher benchmarks for ACOs that spent more historically; this, in turn, should facilitate participation by these ACOs. (In this respect, CMS’ proposed approach resembles the “regionally trended” benchmark methodology that CMS considered during the rulemaking process that led to creation of the regional adjustment, but ultimately rejected as operationally infeasible. Under the “regionally trended” approach, an ACO’s benchmark would have been set in part by trending forward the ACO’s benchmark during its first agreement period.)

While these proposals represent a step in the right direction, CMS should consider tweaking the prior savings adjustment to make it more effective in combatting ratchet effects. In particular, as currently constructed, the prior savings adjustment does more to address ratchet effects in the short-run than in the long-run. Consider, for example, an ACO that succeeds in reducing per enrollee spending by \$100 relative to its benchmark in its first agreement period. For an ACO that has spending above the regional average, the prior savings adjustment will ensure that at least \$50 of those savings remain in the ACO’s benchmark in its second agreement period. However, if the ACO maintains its performance at the same level in this second agreement period, its savings for that period will be just \$50, so its prior savings adjustment in a third agreement period may fall as low as \$25.

While it is likely appropriate for prior savings adjustments to decline over time (e.g., to take account of the tendency of spending by high-cost ACOs to “regress to the mean”), the pace of the decline that would occur under CMS’ current proposal may be too rapid. As a result, some ACOs may still face overly strong ratchet effects. To address this issue, CMS could consider modifying how it calculates the prior savings adjustment. In particular, it could start with a high percentage (e.g., 80%) of any prior savings adjustment in effect for the last agreement period and only subject any *additional* savings to the 50% discount factor that generally applies to savings beyond the amount required to offset a negative regional adjustment. In the example laid out in the preceding paragraph (and using the 80% figure suggested above), this alternative calculation would result in a prior savings adjustment of at least \$40 (= 0.8 x \$50) in the ACO’s third agreement period, rather than as little as \$25.

More generally, while CMS’ proposed benchmark methodology is appropriate in an environment where providers who opt out of the MSSP face few negative financial consequences, relying on a prior savings adjustment still has important downsides, downsides that CMS could avoid if it were harder to opt out of the MSSP.

To start, prior savings adjustments (and related approaches) are not a permanent solution to the selective participation problems currently plaguing the MSSP. As described above, the prior savings adjustment mitigates

selective participation concerns by taking advantage of information on an ACO's pre-MSSP (or early-MSSP) spending that is embedded in the ACO's prior benchmarks. However, that information will gradually become "stale" over time. As that happens, some ACOs will once again begin to face benchmarks that are too low to allow them to participate, while others will face benchmarks that offer them large windfalls, recreating essentially the same selective participation problems that exist under the current benchmark methodology.

Additionally, the prior savings adjustment mitigates selective participation concerns by greatly increasing the dispersion in benchmarks across ACOs (and, specifically by giving historically high-cost ACOs much higher benchmarks than they receive now). While this is likely unavoidable in the present environment, an ideal benchmark methodology would seek to place ACOs on a relatively level playing field in order to encourage efficient ACOs to serve more patients and inefficient ACOs to either become more efficient or serve fewer patients. Importantly, this is a respect in which the current benchmark methodology performs relatively well. Thus, if the financial consequences for opting out of the MSSP were stronger and selective participation concerns were correspondingly weaker, it would likely be appropriate for CMS to reduce its reliance on a prior savings adjustment and return to a methodology that relied more heavily on a regional adjustment.

There are a variety of proposals for how policymakers could impose financial consequences on providers who opt out of the MSSP, most of which involve reducing nonparticipating providers' fee-for-service payment rates.<sup>4</sup> Many of these proposals would likely require legislative action, but CMS should consider whether it is feasible to implement any of them administratively, whether through its ordinary rulemaking authorities or using the authority to test payment changes under the Center for Medicare and Medicaid Innovation.

*Recommendation:* CMS should finalize these changes to the benchmark methodology. CMS should consider modifications to ensure that the prior savings adjustment does not "fade out" too quickly. Over the longer-term, CMS and Congress should strengthen the financial consequences of opting out of the MSSP to allow CMS to move back toward a benchmark methodology closer to CMS' current approach.

### **Using a Prospective External Factor to Update the Historical Benchmark**

CMS currently updates an ACO's benchmark within an agreement period using a growth rate equal to a blend of the *realized* growth rate of per enrollee traditional Medicare spending in the ACO's region and nationwide. In the proposed rule, CMS states that it intends to introduce a third component into this weighted average, a *projected* national per enrollee growth rate that it calls Accountable Care Prospective Trend (ACPT). The new ACPT would receive a one-third weight and the existing national-regional blend would receive a two-thirds weight. The ACPT for the full 5-year agreement period would be specified prior to the start of the agreement period.

The proposed rule ascribes three main advantages to this approach. First, by reducing the weight attached to spending growth in the ACO's own region, the proposal would weaken the degree to which an ACO's success in reducing spending translates into a lower benchmark and, in turn, strengthen ACOs' incentives to reduce spending. Second, the proposed rule states that "incorporation of the ACPT would allow for benchmarks to increase beyond actual spending growth rates as ACOs slow spending growth," which CMS suggests would lead

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<sup>4</sup> Matthew Fiedler, "Medicare Physician Payment Reform after Two Years: Examining MACRA Implementation and the Road Ahead," § Committee on Finance (2019), <https://www.finance.senate.gov/imo/media/doc/08MAY2019FIEDLERSTMNT.pdf>; J. Michael McWilliams, Alice Chen, and Michael E. Chernew, "From Vision to Design in Advancing Medicare Payment Reform: A Blueprint for Population-Based Payments" (Brookings Institution, October 13, 2021), <https://www.brookings.edu/research/from-vision-to-design-in-advancing-medicare-payment-reform-a-blueprint-for-population-based-payments/>.

to higher benchmarks and thereby encourage greater MSSP participation. Third, because the ACPT would be specified in advance, it would give ACOs greater certainty about their future benchmarks.

The first of these is indeed a real advantage of CMS' proposal. However, the second purported advantage of the proposal appears to reflect a misunderstanding of how this proposal would function in practice, while the third is actually the principal weakness of this proposal, not an advantage. Let me discuss the latter two issues in turn.

Starting with CMS' claim that the proposal would lead to higher benchmarks, CMS is correct that incorporating the ACPT into trend factors would reduce the degree to which an ACO's benchmark updates would depend on its *realized* performance. *However, it does not follow that this proposal would result in higher benchmarks.* In establishing the ACPT, the Office of the Actuary (OACT) would presumably take account of the spending reductions it expected ACOs to achieve over the next five years. As such, unless CMS believes that OACT's spending growth projections will be systematically too high, the proposed approach will not result in benchmarks that are higher than those under the status quo (in expectation and on average nationwide).

I turn next to CMS' observation that use of the ACPT would give ACOs greater certainty about their benchmarks. While this is true, this proposal would actually *reduce* certainty about what ACOs should really care about, which is their ultimate financial performance. In particular, health care spending trends are affected by many factors that are outside of ACOs' control and hard to predict in advance, including: the emergence of new medical technologies and practice patterns; changes in population health, such as those due to changes in health behaviors or the emergence of new diseases; and macroeconomic developments, which may, for example, affect trends in provider input costs and thus Medicare's payment updates. Experience during the COVID-19 pandemic clearly illustrates how hard it can be to predict spending trends at even short time horizons.

Under the current approach to updating benchmarks, ACOs' financial performance is largely unaffected by these types of unexpected shocks. For example, if a new technology arrives and increases spending, then the blended national-regional growth rate will be higher and each ACO's benchmark will increase accordingly, leaving ACOs' overall financial performance roughly unchanged. By contrast, this will no longer be the case under the ACPT proposal. If a shock causes spending to be higher than expected, then ACOs' benchmarks will no longer increase dollar-for-dollar, and ACOs' ultimate financial performance will deteriorate; similarly, if a shock causes spending to be lower than expected, then ACOs will receive a windfall.

This sensitivity to projection errors would have deleterious effects on the MSSP. It would increase the financial uncertainty associated with MSSP participation, which could make participation less attractive to providers. It could also induce selective participation; ACOs would remain in MSSP if the ACPT turned out to be too high relative to actual spending trends, while they would drop out if the ACPT turned out to be too low. In expectation, this type of selective participation could have substantial costs for the federal government.

The proposed rule recognizes the potential problems created by projection errors and includes proposals intended to mitigate them. Notably, if an ACO incurs losses that exceed its minimum loss rate for a performance year, CMS proposes to (partially) substitute the existing national-regional blend for the new three-way blend that includes the ACPT when conducting financial reconciliation calculations. CMS also indicates that it may choose to reduce the weight on the ACPT if unforeseen circumstances cause actual spending growth to differ significantly from projections. While these proposals would indeed mitigate the downsides of adopting the ACPT, they are tantamount to a promise to "turn off" use of the ACPT if it ever ends up mattering in practice, which raises serious questions about the rationale for incorporating the ACPT in the first place. It is also important to note that CMS would likely face considerable resistance if it attempted to reduce the weight on an overly generous ACPT after the fact. If CMS failed to reduce that weight, the fiscal cost of this proposal would remain large.

Importantly, alternative approaches would be more effective in achieving the objectives CMS seeks to achieve via the ACPT while also avoiding the main problems of the ACPT proposal. First, as CMS discusses in the proposed rule, CMS could use broader geographic regions to compute the regional component of the national-regional blend, especially in cases where an ACO accounts for a large fraction of its region; this would further weaken the link between an ACO's own performance and its benchmark and, thus, strengthen incentives to reduce spending. Second, rather than determining payment updates using the existing national-regional blend, CMS could use the blended national-regional growth rate plus some fixed amount, like 0.25 percentage points. Unlike the ACPT proposal, this approach would succeed in addressing the concern that ACOs' success in reducing spending is depressing overall spending growth in traditional Medicare and, in turn, generating inadequate benchmarks. It would also do so without introducing the projection error problems of the ACPT proposal.

If CMS is determined to rely on projections to update ACO benchmarks, perhaps because ACOs wish to track their performance during the year relative to a known numerical target, there are ways to reduce (albeit not eliminate) the problems with the current proposal. In particular, CMS could establish the ACPT on an annual basis, rather than five years in advance. Shorter-term projections are still subject to projection errors, but less so than longer-term projections, especially because projection errors would no longer compound over time.

*Recommendation:* CMS should not finalize its proposal to begin updating benchmarks in part based on the ACPT. Instead, it should broaden the geographic regions used to compute the regional component of the existing national-regional blend and consider increasing that growth rate by a fixed amount. If CMS opts to rely on projections, it should establish the ACPT annually rather than for the full 5-year agreement period.

### **Modifying the Risk Adjustment 3% Cap**

To insulate ACOs from the financial consequences of changes in patient mix over the course of an agreement period, CMS adjusts for changes in the risk scores of an ACO's beneficiaries between the benchmark years and the performance years. Under current policy, CMS limits the allowable increase in risk scores over the course of an agreement period to 3%. The proposed rule would relax this cap by, roughly speaking, allowing risk scores to increase by 3 percentage points beyond the increase in risk attributable to demographics alone.

This proposal has important potential benefits. Effective risk adjustment discourages ACOs from taking steps to attract healthier beneficiaries or avoid sicker ones. It also makes program participation more attractive by reducing ACOs' exposure to financial risk stemming from fluctuations in patient mix. Relaxing the cap on risk score growth would allow risk adjustment to do a better job of meeting these goals in cases where ACOs experience large increases in risk scores, which may often be the cases where risk adjustment is most important.

On the other hand, as CMS highlights in the proposed rule, relaxing the cap would also have a downside. Namely, it would increase ACOs' incentives to identify and code their patients' diagnoses in an effort to raise risk scores. Experience from Medicare Advantage (MA) shows that this is not an idle concern.<sup>5</sup> Importantly, ACO coding efforts would represent a waste of real resources since resources that ACOs invest in identifying and coding patient diagnoses will likely do little or nothing to improve patient care.

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<sup>5</sup> Michael Geruso and Timothy Layton, "Upcoding: Evidence from Medicare on Squishy Risk Adjustment," *Journal of Political Economy* 128, no. 3 (March 2020): 984–1026, <https://doi.org/10.1086/704756>; Medicare Payment Advisory Commission (MedPAC), "Medicare Payment Policy," March 2022, [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf).

However, contrary to what CMS asserts in the proposed rule, more aggressive diagnosis coding by ACOs probably would not necessarily increase costs to the federal government, a key difference from the MA context. While successful ACO coding efforts would indeed directly increase ACOs' shared savings payments (or reduce their shared loss payments), they have the side effect of increasing coding intensity in traditional Medicare. That in turn, would reduce the difference in coding intensity between traditional Medicare and MA, which would likely reduce payments to MA plans. At current levels of MA market share, Medicare spending would most likely fall on net, even after accounting for increases in MA benchmarks due to the higher shared savings payments.<sup>6</sup> (Relaxing the cap would, of course, have some cost even without new coding efforts purely because the cap is binding for some ACOs under the status quo, who would benefit at the federal government's expense.)

On balance, my judgement is that the potential benefits from more complete risk adjustment outweigh the potential increase in ACO coding efforts, particularly since more aggressive coding by ACOs may actually have fiscal *benefits* for the Medicare program. In fact, I would encourage CMS to consider going further and eliminating the cap on risk score growth entirely. In its place, CMS could consider implementing a coding intensity adjustment similar to the one currently in place in MA. Regardless, CMS should make continued improvements to its risk adjustment methods that reduce the scope for either ACOs or MA plans to increase their risk scores through coding efforts and thus reduce the real resources wasted in this area.

*Recommendation:* CMS should finalize its proposal to relax the 3% cap. It should consider going further by eliminating the cap entirely and implementing an appropriate coding intensity adjustment. Regardless, CMS should make additional reforms to its risk adjustment systems that reduce their vulnerability to coding efforts.

I hope that these comments are helpful to you as you continue your efforts to improve the MSSP.

Sincerely,

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<sup>6</sup> Suppose, for example, that ACOs' coding efforts increased average risk scores in traditional Medicare by 1%. This would increase per enrollee traditional Medicare spending much less than one-for-one, for several reasons: shared savings rates are typically well less than one; not all ACOs are eligible for shared savings; ACOs are judged in part relative to the performance (and coding efforts) of *other* ACOs); and rebasing tends to attenuate the benefits that ACOs receive from higher coding intensity. A reasonable estimate is that traditional Medicare spending would rise by something less than 0.5%. But this implies that payments to MA plans would *fall* by somewhat more than 0.5%, representing the net effect of reduced relative coding intensity in MA and the mechanical increase in benchmarks from higher shared savings payments. In the current environment where MA accounts of around half of Medicare enrollment, the second effect would be larger, so spending would most likely fall on net. Of course, if CMS responded to increased coding intensity in traditional Medicare by reducing its efforts to combat MA plans' coding efforts, that could offset any savings from increased coding intensity in traditional Medicare. However, because the MA coding intensity adjustment is currently at the statutory minimum, the scope for CMS to respond in this way may be fairly limited at present.