



September 1, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Comments on the CY 2023 Medicare Physician Fee Schedule Proposed Rule [File code CMS-1770-P]

Dear Administrator Brooks-LaSure:

Arnold Ventures welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) “Calendar Year Physician Fee Schedule Proposed Rule” that was published in the Federal Register on July 7, 2022.

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. Our work on provider payment reform aims to re-orient the health care system toward delivering higher quality, less costly care that improves health outcomes. A primary focus is accelerating the adoption of population-based, patient-focused payment models, such as accountable care organizations (ACOs), which give providers greater flexibility to deliver the care their patients need while holding them accountable for quality and total cost of care. Population-based payment models are a promising alternative to the fee-for-service payment system, which often results in inefficient and inequitable care.

First, we want to thank the agency for its important work to improve the Medicare Shared Savings Program (MSSP) given your many competing priorities, and for the opportunity to provide input. The MSSP has demonstrated the ability to generate modest net savings and has enabled participating providers to maintain or improve quality. These findings underscore an important opportunity for CMS to build on the successes of the MSSP, specifically by increasing participation and strengthening incentives for ACOs to reduce spending in the Medicare program. The MSSP is a key platform to build upon to shift more providers and the Medicare beneficiaries they treat into accountable care models.



The changes to the MSSP included in the proposed rule are a major step towards strengthening incentives for providers to participate in ACOs and achieve savings. As such, Arnold Ventures strongly supports the direction that these proposed changes will take the MSSP on balance.

We are particularly supportive of CMS' efforts to maintain participation among existing ACOs to support the long-term sustainability of the program and to increase incentives for less-efficient (high-spending) ACOs to enter the program, given that they present the greatest potential for savings. We are also supportive of CMS' explicit focus on increasing participation among providers who have been underrepresented in population-based payment models including providers serving underserved, high-cost beneficiary populations. Increasing participation among safety net providers is critical to advancing the Administration's goals for equity-centered payment reform and ensuring that all patients have access to providers participating in the MSSP.

We appreciate the challenge of balancing between increasing participation and lowering Medicare spending in the context of voluntary participation. The proposed changes will help increase MSSP participation, which has slowed in recent years, by addressing key issues with the current benchmarking approach. We think some proposed changes, for example reducing the negative effect that ACOs' successful performance has on their benchmark, can improve both participation and savings incentives. However, we are concerned that other changes, particularly the slower shift to two-sided risk proposed for certain ACOs, could undermine the program's savings and weaken providers' incentives to make practice changes that reduce costs.

We strongly support CMS' consideration of transitioning to administrative benchmarks over the longer term and the initial steps in that direction taken in the proposed rule. In addition, in future years' rulemaking, we urge CMS to consider larger scale reforms to the risk adjustment approach and the use of limited mandatory participation and other levers to move providers from fee-for-service into ACOs. We also encourage CMS to contemplate future changes to increase beneficiary engagement in ACOs and allow beneficiaries to benefit (e.g., by reducing beneficiary cost-sharing or providing the opportunity for beneficiaries to share in an ACO's savings).

Our comments in this letter focus on the following proposed changes:

- Revisions to the benchmarking methodology, including accounting for prior savings, reducing the impact of the negative regional adjustment, and incorporating a prospective, external factor in growth rates used to update the historical benchmark
- The transition to performance-based risk
- Advance investment payments to select ACOs
- Modifications to risk adjustment calculations



Changes to the Benchmarking Methodology

The methodology for setting benchmarks in the MSSP is fundamental to the success of the program and should increase and sustain participation while creating strong savings incentives. To achieve this dual aim, the benchmarking methodology must: 1) address ratcheting effects that penalize ACOs for successfully reducing spending, 2) create stronger incentives for high-cost ACOs to join the program, and 3) establish a more stable and predictable target for ACOs. The proposed rule is a major step toward these objectives.

Adjust ACO Benchmarks to Account for Prior Savings

Under the current benchmarking approach, ACOs that have had success in lowering spending are subsequently penalized for that success by having their benchmarks ratcheted downward to reflect more recent historical spending at the start of a new agreement period. This “rebasing” of benchmarks to reflect spending in the prior period essentially penalizes the ACO for its earlier success by making it more difficult for the ACOs to achieve savings in the future, weakens incentives for ACOs to reduce spending, and may unintentionally contribute to selective exit from the MSSP.

CMS has proposed accounting for the prior achieved savings when establishing benchmarks for renewing and re-entering ACOs. This proposed change will help address the ratchet effect that occurs when rebasing benchmarks. It will also help mitigate a related ratcheting issue, which penalizes ACOs in rural areas when they reduce spending. Because these ACOs typically have a high share of the market in a given region, their benchmarks are adjusted downward when they lower spending in their region through their own successful performance. The proposed prior savings adjustment will help offset this effect.

We strongly support CMS’ proposed change to adjust ACO benchmarks to account for prior savings. This proposed change would mitigate harmful ratcheting effects that have undermined long-term participation in the program among high-performing ACOs, in addition to strengthening ACOs’ incentives to reduce wasteful spending.

Reducing the Impact of the Negative Regional Adjustment

The current benchmarking methodology takes into account an ACO’s historical spending and makes an adjustment based on the spending in the ACO’s region. For ACOs that have spending that is higher than the regional average, the regional adjustment reduces their initial benchmark below their historical spending level, which makes it more difficult for them to achieve shared savings. As a result, ACOs with higher spending relative to their region are less likely to join the



MSSP (and exited the program in greater numbers when the policy was initially introduced) due to concerns that they will not be able to spend below their initial benchmark and achieve success in the program.^{1,2} Because the current negative regional adjustment policy discourages high-spending ACOs from joining the program, it has led to selection bias that undermines the program's prospects for generating savings to Medicare. Reducing the participation of high-spending ACOs in the MSSP misses an important opportunity to constrain overall spending as these ACOs represent the greatest potential for savings. The evidence suggests that ACOs with baseline spending above regional averages (high-cost ACOs) generated significantly more savings for Medicare than those ACOs with baseline spending below regional averages (low-cost ACOs).^{3,4}

In addition, ACOs with a high proportion of high-need beneficiaries (e.g., dual-eligible beneficiaries) are more likely to be high spending, given the higher costs associated with caring for this medically complex population. To the extent that the current risk adjustment methodology does not fully account for these differences in cost, the existing regional adjustment is also likely to deter participation among this group of providers. The underrepresentation of these providers in the MSSP raises concerns about equity and should be addressed to advance the Administration's goals to increase ACO participation among providers serving underserved beneficiaries so that all beneficiaries have equal access to providers participating in accountable models.⁵

We strongly support CMS' proposed change to reduce the negative regional adjustment. This will improve the incentives for higher spending ACOs to enter into the program, thus increasing the potential for higher overall savings to the Medicare program. **We are also supportive of the proposal to further decrease the negative regional adjustment amount as an ACO's proportion of dually eligible beneficiaries increases and/or its risk scores increase** given its potential to help increase ACO participation among providers serving underserved beneficiaries, addressing important equity concerns with the existing policy.

¹ J. Michael McWilliams, Bruce E. Landon, Vinay K. Rath, and Michael E. Chernew. [Getting More Savings from ACOs: Can the Pace be Pushed?](#) New England Journal of Medicine, 380(23). June 2019.

² Michael E. Chernew, Andres de Loera-Brust, Vinay Rath, and J. Michael McWilliams. [MSSP Participation Following Recent Rule Changes: What Does It Tell Us?](#) Health Affairs Forefront. November 22, 2019.

³ J. Michael McWilliams and Alice J. Chen. [Understanding The Latest ACO "Savings": Curb Your Enthusiasm and Sharpen Your Pencils—Part 1.](#) Health Affairs Forefront. November 12, 2020.

⁴ J. Michael McWilliams, Laura A. Hatfield, Michael E. Chernew, Bruce E. Landon, and Aaron L. Schwartz. [Early Performance of Accountable Care Organizations in Medicare.](#) New England Journal of Medicine, 374(24). June 2016.

⁵ Chiquita Brooks-LaSure, Elizabeth Fowler, Meena Seshamani, and Daniel Tsai. [Innovation at the Centers for Medicare and Medicaid Services: A Vision for the Next 10 Years.](#) Health Affairs Forefront. August 12, 2021.



Incorporating a Prospective, External Factor in Growth Rates Used to Update the Historical Benchmark

Arnold Ventures supports the incorporation of an external factor to update the historical benchmark and the gradual transition to administrative benchmarks considered in CMS' related Request for Information. Administrative benchmarks hold great promise for increasing participation in the MSSP and strengthening incentives to save over the long term.

A transition to administrative benchmarks, where benchmark updates are tied to exogenous factors such as inflation or the gross domestic product, creates an opportunity to transform the current approach to setting benchmarks in a way that could increase participation in the program and strengthen incentives to save. An administrative benchmark has several advantages. One advantage of administrative benchmarks is that they would address the problematic ratcheting effects described above by disconnecting benchmarks from observed fee-for-service spending and ACOs' performance. The benchmarks could also be updated in a manner that allows spending to rise at a slower rate over time than projected. The objective would be to lower spending below projected (fee-for-service) levels, generating savings for the Medicare program, while still allowing ACOs to share in the savings as they become more efficient. Under the current benchmarking approach, lower spending by ACOs results in benchmarks trending forward more slowly, forcing ACOs to continually find new efficiencies and further lower spending to be successful. Administrative benchmarks could instead give ACOs greater incentives to remain in the program for the long-term and to save.

Another advantage of administrative benchmarks is that they add stability and predictability to the benchmarks. Because benchmarks are currently updated based on actual changes in spending, ACOs do not learn their final benchmark until half way through the year following a performance year, limiting the ability to track targeted population health management approaches against their benchmarks. Under an administrative benchmarking methodology, ACOs would know their benchmarks from the start, which would enhance their ability to monitor their progress relative to their spending target. They would also be more operationally stable as ACOs become more widely adopted in traditional Medicare and the remaining fee-for-service population shrinks.

We support CMS' consideration of administrative benchmarks and the steps taken in the proposed rule and related Request for Information to move in this direction. In particular, CMS' proposal to introduce a preset, external growth rate and initially blend it with the existing regional and national growth rates to determine benchmark updates is a reasonable starting



point given the complexity of this transition and the need for a gradual process. As CMS contemplates a concrete vision for this transition, we encourage CMS to consider the following:

- **Create a glidepath to administrative benchmarks with the goal of mitigating short-term windfall gains and losses for incumbent ACOs.** This will require CMS to articulate a process for phasing in administrative benchmarks over a defined period and deciding whether and how quickly for spending to converge within and between regions. Moving to a pre-set national update factor will create winners and losers among existing ACOs in part due to regional variations in spending. A well-designed approach that contemplates the potential for large losses is needed to protect current MSSP participants from exiting the program during the transition period.
- **Use the administrative benchmark update factors to create a “wedge” between fee-for-service spending and ACO spending growth, as described in McWilliams, Chen, and Chernew’s recent blueprint for population-based payment models.**⁶ This proposal would create a payment differential for providers in ACOs compared to those not in ACOs, and the differential would increase over time. Such a structure would create better incentives for long-term participation in the program by allowing the ACOs to share in the savings and continually benefit from their greater efficiency while ensuring long-term savings potential for the government.
- **Contemplate how to protect against forecast errors and shocks to the environment that could have severe unintended consequences, such as those created by a new pandemic or expensive technological advancement. This will also be an important consideration for the proposed near-term change to blend in an external growth factor.** Because CMS Office of the Actuary’s (OACT) projected growth in spending will inform the administrative benchmark, CMS must contemplate how it will account for forecast errors that create large and unexpected gains and losses. For example, if OACT substantially underestimates spending growth during the initial phase-in of an administrative benchmark update factor, ACO participation could decline significantly. It will be necessary for there to be guardrails to protect against these kinds of unanticipated scenarios.

Overall, the proposed use of an external growth factor blended with the existing regional-national spending blend represents an important step toward increasing participation in the MSSP and strengthening incentives to save. We commend CMS for taking up this challenging task.

⁶ J. Michael McWilliams, Alice Chen, and Michael E. Chernew. [From Vision to Design in Advancing Medicare Payment Reform: A Blueprint for Population-based Payments](#). USC-Brookings Schaeffer Initiative for Health Policy. October 13, 2021.



Transition to Performance-Based Risk

In order to achieve the ambitious goal of moving all providers into effective population-based payment models, we recognize there needs to be a glidepath that enables providers in fee-for-service to first gain experience with alternative payment models under one-sided risk models before ultimately moving into two-sided risk models that put providers at financial risk for exceeding their benchmark. We believe that glidepath should vary based on providers' ability, experience, and market characteristics. Certain providers (e.g., large health systems and multi-specialty physician groups) should be required to move into two-sided risk models more quickly than others (i.e., smaller or inexperienced providers). Other providers (e.g., certain safety net providers) may be able to take on two-sided risk with a longer transition period and additional incentives and supports to enable them to enter two-sided risk models (such as simplified payment structures that enable more flexibility and upfront payments). We recognize the selective participation effects and potential savings impacts from moving too quickly to two-sided risk, as evidenced by the large number of ACOs that exited the MSSP when faced with downside risk in the Pathways to Success program.^{7,8} That said, the goal should be to move most providers to two-sided risk over time. Compared to one-sided risk models, two-sided risk models pose fewer risks for Medicare spending and create greater incentives for providers to reduce spending and invest in transforming care delivery.

While the evidence on selective participation after the implementation of the “Pathways to Success” changes suggests a need to reconsider the glidepath to two-sided risk, we are concerned that the proposed changes to the risk model selection are insufficiently targeted. We encourage CMS to refine the proposed policy by narrowing the eligibility criteria and reducing the amount of time that certain providers can remain in one-sided risk.

The eligibility criteria as currently specified in the proposed rule *only* considers an ACO's experience with performance-based Medicare ACO initiatives rather than considering other factors that may more narrowly target the subset of providers CMS intends to reach—namely, ACOs that need more time to transition to two-sided risk due to lack of experience and resources. Furthermore, CMS has expanded the definition of “performance-based risk Medicare ACO initiative” to include *renewing or re-entering* ACOs that were previously under a one-sided risk

⁷ J. Michael McWilliams, Bruce E. Landon, Vinay K. Rathi, and Michael E. Chernew. [Getting More Savings from ACOs: Can the Pace be Pushed?](#) New England Journal of Medicine, 380(23). June 2019.

⁸ William K. Bleser, Robert S. Saunders, David Muhlestein, Andrew Olson, Robert Richards, Donald H. Taylor, and Mark B. McClellan. [Following Medicare's ACO Program Overhaul, Most ACOs Stay—But Physician-Led ACOs Leave at a Higher Rate.](#) Health Affairs Forefront. March 15, 2019.



model (i.e., levels C through E of the BASIC track). Consequently, these criteria may allow well-resourced providers that have participated in the program and that are capable of moving to two-sided risk more quickly to remain in one-sided risk longer than necessary. Refining the eligibility criteria would enable providers that do not require such a long on-ramp to take on two-sided risk sooner, which could provide stronger incentives for ACOs while offering greater protection for the Medicare trust fund.

Allowing a more generous on-ramp to two-sided risk may increase participation in the MSSP, but it may do so at the expense of the program's effectiveness in constraining spending. We encourage CMS to contemplate the tradeoffs of having a smaller but more effective program versus a larger program that is less effective. In addition, while smoothing the transition to two-sided risk may help increase participation in the program, CMS should contemplate whether fully implementing this proposed change is necessary, as other provisions in the proposed rule (such as the benchmark methodology changes discussed above and the new advance investments discussed next) will also help address participation concerns.

Finally, balancing between moving providers to two-sided risk and increasing participation in the MSSP is complicated by the voluntary nature of the program. To that end, we also encourage CMS to contemplate transitioning the MSSP to a mandatory model, at least for providers who are better able to take on financial risk (e.g., large systems), given experience with the model to date and to consider other available policy levers to incentivize providers to participate in ACOs (e.g., changes to fee-for-service) in future rulemaking. Increasing participation in models with downside risk will likely require the use of these types of strategies.

Advance Investment Payments

Participating in the MSSP requires significant start-up investment costs, which can be a major barrier for ACOs without access to capital or serving underserved populations. Findings from CMMI's model test of the ACO Investment Model (AIM), which provided upfront funding to 41 ACOs in rural and underserved areas, suggests that advanced investment payments can be an effective tool for enabling greater ACO participation among providers that would be unlikely to join the program otherwise due to their resource constraints. The AIM generated an estimated net aggregate reduction in spending by Medicare of \$381 million after accounting for non-recouped Medicare's payments of AIM funds and ACOs' shared savings bonuses.⁹ It is also worth

⁹ Matthew J. Trombley, J. Michael McWilliams, Betty Fout, and Brant Morefield. [ACO Investment Model Produced Savings, But The Majority Of Participants Exited When Faced With Downside Risk](#). Health Affairs, 41(1). January 2022.



noting that AIM ACOs relied heavily on management companies to set up and operate their ACO, with the aggregator Caravan Health managing about half of the AIM ACOs.¹⁰

Given the success of the AIM in both increasing participation and generating government savings, we are generally supportive of CMS’ proposal to provide advance investment payments to select ACOs. We also support CMS’ proposal to limit the purposes these funds can be spent on and to track how ACOs use funds so the effects of this policy can be monitored. Although we are supportive of this policy and its intent, we encourage CMS to refine the inclusion criteria so it sufficiently targets upfront funding only to the ACOs most likely to benefit.

The intent of the advance investment payment is to increase MSSP participation among safety net providers and those serving rural populations. One of the qualifications to receive advance investment payments is that the ACO must be considered a “low revenue ACO” as defined in § 425.20. As articulated in the rule, these ACOs tend to be small, physician-only ACOs that are less resourced. This definition captures smaller ACOs with diverse patient populations but it allows for a broader eligibility than the AIM model, which specifically targeted safety net providers and those serving rural populations. The definition in this proposed provision may be too expansive in its application, which could undermine CMS’ intent to enhance equity by targeting ACOs that serve specific populations and that have historically been underrepresented in payment reform.

CMS should reevaluate whether the definition of low revenue best captures the ACOs that lack upfront capital and sufficiently excludes providers that have the capital to join without government investment. We suggest that CMS closely monitor the effects of this proposed new component of the program with specific attention to the characteristics of ACOs receiving advance investment payments and effects on overall program participation and savings.

Improving the Risk Adjustment Methodology to Better Account for Medically Complex, High Cost Beneficiaries and Guard Against Coding Initiatives

CMS’ approach to risk adjustment must balance incentives for ACOs to care for high-risk and costly beneficiaries against ACOs’ incentives to intensify risk coding. CMS’ current policy of capping ACOs’ cumulative risk score growth at 3% for each five-year agreement period has

¹⁰ Lauren M. Scarpati, J. Michael McWilliams, Heather McPheron, Betty T. Fout, Matthew J. Trombley. [How ACOs in Rural and Underserved Areas Responded to Medicare’s ACO Investment Model](#). Health Affairs Forefront. November 10, 2020.



helped limit the impact of unwarranted benchmark and payment increases due to coding incentives. However, it may not sufficiently encourage ACOs to care for high-risk beneficiaries.

On balance, we support CMS' efforts to improve its risk adjustment approach to better account for ACOs caring for medically complex, high-cost beneficiaries by imposing a 3 percent cap in excess of growth in demographic risk score. In this proposed change, CMS would account for changes in ACOs' demographic risk scores before applying the 3% cap. Also, the proposed change would calculate an aggregate 3% cap across all four enrollment types (i.e., dual-eligible, disabled, end-stage renal disease, and aged) rather than calculating and applying a separate 3% cap to each type individually. The change to the aggregate cap would make it less likely for the cap to apply when there are smaller sample sizes of high-need enrollment types (i.e., dual-eligible, disabled, and end-stage renal disease population).

By enabling more accurate and appropriate payment for high-need beneficiaries, this policy could strengthen incentives for ACOs to care for this underserved population. This policy change could also help facilitate increasing the number of providers and enrollees in the MSSP, with a particular focus on enhancing equity by targeting underserved populations and ensuring they have access to providers in the MSSP.

We strongly support CMS retaining a cap on risk score growth in the MSSP, as well as the proposed use of demographic risk score changes as they are less susceptible to coding incentives than if the policy allowed benchmarks to increase further on the basis of claims-based risk scores. We underscore the importance of protecting against greater coding intensity and unwarranted spending increases. We have seen the impact of unfettered coding intensity in the Medicare Advantage program where beneficiaries' risk scores in 2020 were nearly 10 percent higher than risk scores for similar beneficiaries in traditional Medicare, resulting in \$12 billion in excess payments in 2020 after accounting for CMS' coding adjustment.¹¹

Greater participation in population-based payment models like ACOs, as well as certain features of the MSSP such as the use of regional spending in the benchmarks, increase the importance of having an effective risk adjustment approach. Evidence suggests that the current risk adjustment model, which determines risk scores used in the MSSP and Medicare Advantage, is not up to the task as reliance on risk adjustment to make accurate and fair payments increases. **We encourage CMS to use future rulemaking to contemplate more fundamental changes to the risk**

¹¹ Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. The Medicare Advantage Program: Status Report and Mandated Reports on Dual-eligible Special Needs Plans (Chapter 12). March 2022.



adjustment model. Risk adjustment must accurately predict variation in health risk and costs across providers/plans and mitigate provider/plan selection incentives. It should limit the ability of providers/plans to profit from intensive coding, including by reducing reliance on diagnoses reported by providers/plans. A recent study comparing risk scores from the current risk adjustment approach to those derived from CAHPS found significant differences between these two measures of beneficiary risk, suggesting coding intensity is an issue in ACOs, similar to the behaviors observed in Medicare Advantage plans.¹² This finding points to the need for CMS to consider new sources of data to measure risk and reduce the reliance on plan/provider submitted data. Given the flaws in CMS' current risk adjustment model, which contribute to inequitable and excessive compensation for care, larger scale changes to CMS' risk adjustment approach are needed.

A key limitation with the current risk adjustment approach is the model's ability to accurately predict payment for certain subsets of patients. This lack of accuracy can lead to providers being inappropriately overcompensated for the care of some patients and undercompensated for the care of other patients, which weakens incentives for providers who serve underserved populations to participate in the MSSP and may create perverse incentives for ACOs to drop clinicians that have high-risk panels. Changes to the current risk adjustment methodology could enable a re-allocation of health care payments across ACOs to better reflect the resources needed to care for more costly patients with higher medical complexity and greater social risk.

In addition, the risk adjustment system could be designed to advance equity goals, including by redistributing payments to adjust for historical patterns of underspending without altering the total amount being spent. The model's current reliance on historical spending to determine payment can predict spending levels that are not socially desirable to replicate. For groups that have historically received too little care, the current approach to risk adjustment will accurately predict lower spending, thereby perpetuating health disparities. Correcting for this issue (i.e., redistributing payments to enable higher payments for the care of historically underserved groups and lower payments for the care of historically overcompensated groups) is important for allocating resources in population-based payment models in a way that advances health equity.

¹² Michael E. Chernew, Jessica Carichner, Jeron Impreso, J. Michael McWilliams, Thomas G. McGuire, Sartaj Alam, Bruce E. Landon, and Mary Beth Landrum. [Coding-Driven Changes in Measured Risk in Accountable Care Organizations](#). Health Affairs, 40(12). December 2021.



Conclusion

We appreciate the Administration's commitment to building off the success of the MSSP. The overall direction of the proposed changes to the MSSP represents an important opportunity to strengthen the program and a major step forward. We support the focus on increasing participation among providers who have been underrepresented in the program and face challenges to participation, including low-revenue providers, providers serving high-cost and underserved populations, and ACOs with high baseline spending that are less likely to enter the program under current policy. In addition, these changes will mitigate challenges that have impeded ACOs from participating in the program for the long-term. Overall, we are encouraged that these changes will increase participation and strengthen incentives to save, with an admirable focus on advancing health equity.

Again, we appreciate the opportunity to comment on the proposed rule. Please contact Erica Socker at esocker@arnoldventures.org or Mark Miller, Ph.D., Arnold Ventures' Executive Vice President of Health Care, at mmiller@arnoldventures.org with any questions.

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