NAACOS Analysis of the CY 2023 Proposed Medicare Physician Fee Schedule

Executive Summary

On July 7, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2023 Medicare Physician Fee Schedule (MPFS) Proposed Rule. This proposed regulation includes several positive changes to the Medicare Shared Savings Program (MSSP) for which NAACOS has long advocated.

In this analysis, we provide details on key proposals impacting ACOs. The rule is summarized in several fact sheets provided by CMS: MPFS Fact Sheet, MSSP Fact Sheet and Quality Payment Program (QPP) Fact Sheet.

NAACOS is seeking member input on the proposals in this rule, which will help shape our comments. Please share your feedback by emailing us at advocacy@naacos.com. Comments to CMS in response to the proposed rule are due on September 6 and may be submitted on the regulations.gov website. NAACOS will provide draft comments ahead of the deadline.

CMS will review comments and issue a final rule later this year. Typically, the MPFS Final Rule is released by November 1.

Medicare Shared Savings Program Proposals

- Change the "Pathways to Success" glidepath to allow more time before advancing to risk for certain ACOs*
- Incorporate a prospectively projected administrative growth factor into a three-way blend with national and regional growth rates to update an ACO's historical benchmark for each performance year*
- Reduce the cap on negative regional adjustments from -5 percent to -1.5 percent*
- Account for an ACO's prior savings in rebased benchmarks to help mitigate the lowering of an ACO's benchmark over time*
- Revise how CMS applies the existing 3 percent cap on HCC risk score*
- Change the quality scoring approach to allow more ACOs to achieve some savings*
- Add a health equity adjustment increase for ACOs serving high proportions of underserved beneficiaries
- Provide advance investment payments to certain ACOs*
- Seek comment on the impact of the advanced APM incentives ending*

*Denotes policies for which NAACOS has long advocated

Medicare Physician Payment Proposals

- Decrease the Medicare conversion factor from $33.59 to $33.08
- Update other evaluation and management (E/M) visits to allow for time or medical decision making
- Implement telehealth provisions established in the Consolidated Appropriations Act (CAA) of 2022

MEDICARE SHARED SAVINGS PROGRAM

Pathways to Success Glidepath to Risk

NAACOS has long advocated for CMS to reverse policies finalized in 2018 under the Pathways to Success Rule, which accelerated the move to risk-based tracks for ACOs. Since implementation of Pathway to Success, NAACOS repeatedly shared concerns with CMS regarding the low program growth and urged the agency to return to a more balanced approach to transitioning to risk. In this rule, CMS proposes significant changes to the current Pathways to Success glidepath:

- Providing up to seven years in upside-only tracks for inexperienced ACOs
- Providing up to 12 years in upside-only tracks for new, inexperienced, low-revenue ACOs
- Allowing ACOs currently in upside-only tracks (Tracks A and B) to remain in upside-only for the duration of its agreement
- Making the Enhanced Track optional for all ACOs

NAACOS is pleased to see these proposals and will continue to advocate for policies that will attract new MSSP participants and allow current participants to succeed in the model.

ACOs Inexperienced with Risk

CMS proposes to provide ACOs inexperienced with performance-based risk with seven years of participation in the program before being required to take on risk in the eighth year. Specifically, starting January 1, 2024, and in subsequent years, ACOs inexperienced with performance-based risk would be allowed to participate in one five-year agreement under a one-sided model only (Basic Track Level A for all five years). If the ACO remains eligible, the ACO would also be eligible for an additional five-year agreement period progressing through Basic Track Levels A–E, which is two additional years under upside-only before taking on risk. I If ineligible to continue in the Basic Track for a second agreement period, the ACO would have the option to participate in Basic Track Level E for all five years of the second agreement period or move to the Enhanced Track. An ACO must meet the following requirements:

- The ACO is participating in its first agreement period under the Basic Track
- The ACO is not participating in an agreement period under the Basic Track as a renewing ACO (as defined in § 425.20) or a re-entering ACO (as defined in § 425.20) that previously participated in the Basic Track's glide path
- The ACO is inexperienced with performance-based risk Medicare ACO initiatives

CMS proposes to extend this participation option to re-entering former Track 1 ACOs because these ACOs have not previously participated in the Basic Track glide path. CMS would like to encourage these ACOs to participate in the program again.

ACOs continuing to meet the definition of inexperienced with performance-based risk may enter a second agreement period in the Basic Track's glide path. Specifically:

- The ACO is the same legal entity as a current or previous ACO that previously entered into a participation agreement for the Basic Track's glide path only once; or
- For a new ACO identified as a re-entering ACO, the previous ACO (the ACO in which the majority of the reentering ACO's participants were previously participating) entered into a participation agreement for the Basic Track's glide path only once.

CMS discusses an alternate proposal that would provide low revenue ACOs with no experience with performance-based risk up to 12 years of participation in upside-only before requiring the ACO to bear risk. Specifically, these ACOs would have two agreement periods participating in Basic Track Level A and an additional agreement period progressing through the Basic Track Levels A-E. Eligibility is limited to low

revenue ACOs that enter the Basic Track as new legal entities (i.e., never participated in MSSP and not identified as renewing or re-entering ACOs).

CMS also proposes to amend the definition of performance-based risk Medicare ACO initiative in § 425.20 to include only Levels C through E of the Basic Track. NAACOS advocated for the removal of Basic Track Levels A and B from this definition, and we are pleased to see this proposal.

CMS Monitoring
Beginning with performance periods on or after January 1, 2024, CMS proposes to monitor ACOs identified as inexperienced with performance-based risk. Using a five-year rolling lookback period, CMS will monitor the ACO participant list to determine if the ACO could now be considered experienced with performance-based risk Medicare ACO initiatives, thus ineligible for participation in a one-sided model. For example, CMS will review Performance Year (PY) 2020 through PY 2024 for PY 2025. CMS would perform the same monitoring activity ahead of all subsequent performance years of the agreement period in which the ACO elected to remain in Basic Track Level A. CMS will provide feedback to allow the ACO to assess if the changes to its ACO participant list would yield a determination that the ACO qualifies as experienced with performance- based risk.

If an ACO is determined to meet the definition of having experience with performance-based risk, the ACO would be permitted to remain in its current track for the remainder of the performance year. The ACO would be required to advance to Basic Level E at the start of the next performance period.

ACOs Currently Participating in Basic Track Levels A, B
Beginning on January 1, 2023, CMS proposes to allow ACOs currently participating in Basic Track Level A or B the option to remain in the upside-only Track for during the agreement period.

- ACO Spotlight Issue 13 has additional information on this election process.
- The deadline to make this election in the ACO-Management System is September 9 at 12:00 pm ET.
- CMS notes it will provide ACOs currently participating in Basic Track Level A or B the opportunity to indicate whether the ACO is interested in maintaining participation at Level A or B, should the policy be finalized, during the change request cycle.
- ACOs electing this option would not be required to submit a repayment mechanism at that time.

This option also extends to ACOs applying to participate in the Basic Track Levels A or B for a start date of January 1, 2023.

Enhanced Track Optional
CMS proposes that beginning January 1, 2024, there would be no limitation on the number of agreement periods an ACO can participate in the Basic Track Level E. Accordingly, CMS proposes to make the Enhanced Track optional; ACOs would be able to participate in Basic Track Level E indefinitely. ACOs participating in the Enhanced Track would always have the option to enter a new participation agreement under Basic Track Level E. NAACOS has long advocated for CMS to make the Enhanced Track optional, we are pleased to see these proposals.

Tables 45, Proposed Participation Options (reproduced below), and Table 46, Alternative Participation Option outline the proposed participation options and glide path changes.

ACO Type	Experience with Risk	Participation Options		
		First Agreement Period	Second Agreement Period	Future Agreement Periods
New legal entity	Experienced	A, A, A, A, A	A, B, C, D, E	E indefinitely or ENHANCED
New legal entity	Unexperienced	E, E, E, E, E	E, E, E, E, E	E indefinitely or ENHANCED
Re-entering ACO	Inexperienced-from BASIC-A/B	A, B, C, D, E	E, E, E, E, E	E indefinitely or ENHANCED
Re-entering ACO	Inexperienced-former Track 1	A, A, A, A, A	A, B, C, D, E	E indefinitely or ENHANCED
Re-entering ACO	Experienced	E, E, E, E, E	E, E, E, E, E	E indefinitely or ENHANCED
Currently in BASIC-A/B for 2022	Inexperienced-from BASIC-A/B	Remain A/B for remainder of current agreement	A, B, C, D, E	E indefinitely or ENHANCED
BASIC-A/B beginning 2023	Inexperienced-from BASIC-A/B	Remain A/B for remainder of current agreement	A, B, C, D, E	E indefinitely or ENHANCED
Renewing	Inexperienced	A, B, C, D, E	E, E, E, E, E	E indefinitely or ENHANCED
Renewing	Experienced	E, E, E, E, E	E, E, E, E, E	E indefinitely or ENHANCED

Financial Methodology

NAACOS has long advocated for a fairer, more accurate financial methodology for ACOs. Specifically, we have requested that CMS fix the "rural glitch" by removing ACO-assigned beneficiaries from the regional reference population, increase risk score caps to +/-5 percent, and apply risk score caps to both the ACO and the region. CMS did not make any of these changes in the proposed rule; however, several positive adjustments are proposed. NAACOS is studying the potential impact of CMS's proposals and simulating our own analysis. We are pleased that several proposed changes will help create the fairer, more accurate financial benchmarks, as NAACOS has long advocated.

Addition of a Prospective Update Factor

For agreement periods starting in 2024, CMS proposes to add a prospective administrative growth factor, the "Accountable Care Prospective Trend" (ACPT), to update an ACO's benchmark for each performance year in an ACO's agreement period. This would create a new three-way blend, along with national and regional growth rates. Under policies adopted in 2018's Pathways to Success Rule, CMS uses a national-regional blend that is a weighted average of national fee-for-service (FFS) and regional growth rates between the third benchmark year (BY3) and the performance year for each of the four Medicare enrollment types. The weight assigned to the national component is based on the market penetration across all counties where the ACO has assigned beneficiaries. Under CMS's proposed approach, a three-way blend would be calculated as the weighted average of the ACPT (one-third) and the existing national-regional blend (two-thirds) for updating an ACO's historical benchmark between BY3 and the performance year.

CMS notes that adding this prospective growth factor would insulate an ACO's benchmark from any savings that occur as a result of ACOs' work. The agency does not address the "rural glitch," which occurs when an ACOs lowers its own benchmarks by lowering the spending of its region. However, CMS

indicates its proposal would achieve the same effect as removing ACO-assigned beneficiaries from the regional reference population. In theory, this new three-way blend would allow benchmarks to grow higher than actual spending growth rates, which can be slowed by ACOs. This possibility of both higher benchmarks and greater savings opportunities would entice ACOs to both join and remain in MSSP.

CMS proposes to base the ACPT on the United States Per Capita Cost, which is already calculated by the CMS Actuary and used to base annual rate updates in Medicare Advantage. CMS would calculate ACPT projections at the start of an ACO's five-year agreement period. These projections are expected to be published in the spring of the first performance year. If projections are not uniform over the five-year period, the ACPT could be two or more numbers.

If an ACO generates losses under the proposed three-way blend, CMS would recalculate an updated benchmark using the two-way national-regional blend. CMS would then use the lesser shared loss amount for an ACO's repayment responsibility and resulting financial performance monitoring policy. If the ACO generates losses under the three-way blend but savings under the two-way blend, the ACO would not be responsible for shared losses nor eligible for shared savings even if the ACOs minimum savings rate (MSR) was exceeded.

While ACPT projections would not change during an agreement, CMS would retain discretion to adjust the weight of the ACPT in the three-way blend if actual spending significantly deviated from projections. This could happen for unforeseen circumstances such as an economic recession, pandemic, or other factors. If CMS determines a need to protect against either excessive ACO shared savings or losses, CMS could reduce the weight of the ACPT from a third of an updated benchmark to as low as zero.

Comment Solicitation on Incorporating Administrative Benchmarks

CMS also seeks feedback on how it can implement a prospective, administratively set annual growth rate to update benchmarks. This would be a departure from updating ACO benchmarks on actual FFS spending growth in the ACOs region and nationally. In theory, administratively set benchmarks would allow ACO benchmarks to rise faster as ACOs generate savings, allowing ACOs to retain more savings and thus incentivizing more providers to join and remain in the program.

The approach to updating benchmarks that CMS has used since the program began would systematically lower benchmarks over time as ACOs lower the spending growth of its patients. This "ratcheting" effect has been raised as a point of concern by both the Medicare Payment Advisory Commission (MedPAC) and other health policy thought leaders. This ratcheting effect of financial spending targets becomes more pronounced as more ACOs join the program and fewer patients remain in uncoordinated, FFS Medicare.

In its request for information, CMS seeks comment on several areas regarding administratively set benchmarks, including:

- How to calculate the trend used to update benchmarks;
- Approaches to account for price growth and demographic factors rather than volume and intensity;
- Considerations for guardrails to protect against projection error; and
- Approaches for updating the trend rate that would ensure it does not overly reflect ACOs' collective impact on spending.

Accounting for an ACO's Prior Savings

CMS proposes to account for prior savings when establishing benchmarks for renewing and re-entering ACOs for agreement periods beginning in 2024. CMS stated in the proposed rule that the change would help further mitigate any ratcheting effect that occurs when ACO benchmarks are rebased. It would also

help offset of the rural glitch, where an ACO lowers its benchmark when it lowers the spending on its region through its own assigned patients.

CMS would calculate the simple average per capita savings or losses generated by an ACO during the three years that immediately precede the start of the performance period, the same three years that constitute its baseline. For these calculations, CMS would use all savings generated, not just savings that meet or exceed an ACO's MSR for that performance year. If an ACO is not eligible to receive a prior savings adjustment, the ACO would receive the regional adjustment to its benchmark.

CMS had included a similar "prior savings adjustment" for ACOs starting agreements in 2016 but quickly reversed that policy the following year after it started incorporating regional adjustments into benchmarks. The agency felt at the time that benchmarks would "become overly inflated for some ACOs" benefiting from the regional adjustment. CMS stated in the 2023 proposed rule that this concern remains. To account for this, CMS proposes to adjust prior savings amount depending on whether an ACO has higher or lower spending than its region.

- For ACOs with spending lower than the region. CMS will apply the higher of either (1) the prior savings adjustment multiplied by 50 percent or (2) positive regional adjustment. Halving the prior savings adjustment accounts for ACOs' shared savings rates.
- For ACOs with spending higher than the region. CMS will apply the full prior savings adjustment, which would offset the negative regional adjustments either partially or in full.

The prior savings adjustment would be prorated to account for situations where an ACO's assigned population is larger in its benchmark years than in its current performance year. If an ACO was not reconciled for one or more of its three benchmark years, the ACO would receive zero savings or losses in the calculation of average per capita prior savings for the relevant year(s). For re-entering ACOs, CMS would use per capita savings and losses from the ACO in which the majority of participants were participating. Finally, ACOs not in compliance with MSSP requirements would have savings generated in that year would set to zero for purposes of these calculations.

Reducing the Impact of a Negative Regional Adjustment

CMS proposes to reduce the cap on negative regional adjustments from -5 percent of national per capita FFS spending to -1.5 percent for agreement periods beginning in 2024. This would help ACOs that have spending higher than its region and would receive a higher benchmark after the regional adjustment. CMS would keep the upward cap of +5 percent for ACOs that have lower spending than its region.

In conjunction, CMS proposes to apply an offset factor to the negative regional adjustment based on the proportion of an ACO's dual eligible beneficiaries or its weighted-average hierarchical condition code (HCC) risk score increases. Therefore, the higher an ACO's proportion of dual eligible beneficiaries or the higher its risk score, the larger its overall negative regional adjustment would be reduced.

CMS states it is proposing these changes as part of its efforts to encourage ACO participation and incentivize treating high-cost and medically complex populations. The current -5 percent cap on the regional adjustment may harm ACOs that serve more End-stage Renal Disease (ESRD) and dual eligible patients.

In simulations of its proposed changes, CMS projected that nearly all ACOs would benefit from this change if they had a negative regional adjustment. Furthermore, CMS expects the impacts of its proposed change to grow as more ACOs progress in the program and have higher regional adjustments.

Risk Adjustment Changes

CMS proposes to account for changes in demographic risk scores for an ACO's assigned population between BY3 and the applicable performance year before applying the 3 percent cap on positive HCC scores beginning in 2024. Under the proposal, the +3 percent cap would apply in aggregate across the four enrollment types (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible) after CMS accounts for changes in demographic risk scores. While CMS would calculate a single cap level based on demographic risk scores for the four enrollment types, it would only apply the risk score cap for a particular enrollment type if the aggregate growth in HCC risk scores exceeds the value of the cap. This makes it less likely that risk scores for Medicare enrollment types with smaller populations (typically ESRD, disabled, and dual eligible beneficiaries) would be subject to the cap.

CMS simulated the impact of this proposed change with 2020 data and found 45 percent of ACOs would have had a higher updated benchmark compared to current policy, 5 percent would have had a lower benchmark, and 50 percent would be unaffected because they were not subject to any cap under either policy. CMS acknowledges that some ACOs could receive a lower updated benchmark due to this proposed change if its weighted average demographic risk ratio were low enough. In that case, the existing 3 percent cap on risk scores changes would still apply to the proposed demographic risk score changes.

Additional Shared Savings Opportunities for Low Revenue ACOs Below MSR

CMS proposes to allow low revenue ACOs in the Basic Track the opportunity to earn some shared savings even if the ACO fails to meet or exceed its MSR. Qualifying ACOs would be eligible for half of their maximum shared savings rate, so changes would look as follows:

Risk Level	**Maximum Shared Savings Rate if the MSR is Exceeded**	**Maximum Shared Savings Rate if the MSR is NOT Exceeded**
Basic Levels A and B	40%	20%
Basic Levels C, D, and E	50%	25%

The change would only apply to all low revenue ACOs in the Basic Track, including renewing and reentering ACOs. This option is not available for high revenue ACOs in the Basic Track or ACO in the Enhanced Track. This would take effect for ACOs beginning new agreement periods in 2024. To qualify, the ACO must have at least 5,000 assigned beneficiaries at the time of financial reconciliation and meet the quality performance standard or the proposed alternative quality performance standards. Similar to the approach used for ACOs that exceed MSR, the final savings rate would be multiplied by an ACO's health equity adjusted quality performance standard

Under rule changes instituted by Pathways, one-sided ACOs in the Basic Track have a variable MSR ranging from 3.9 percent for ACOs with 5,000 assigned beneficiaries to 2.0 percent for ACOs with 60,000 or more assigned beneficiaries. Two-sided ACOs in the Basic Track can choose a symmetrical MSR/MLR that ranges from 0 percent to 2 percent (in 0.5 percent increments), or that is variable based on number of beneficiaries assigned to the ACO. This selection occurs before an ACO enters Level C, D, or E and will be in effect for the duration of the agreement period.

CMS explains in the proposed rule that this policy would help incentivize smaller, newer, more resource stricken ACOs to stay in the program and help the administration achieve its goal for 100 percent of patients to be covered by accountable care models. According to NAACOS analysis, a large number of

ACOs generated savings for CMS but not enough to earned shared savings. This included 16 percent of MSSP ACOs in 2020, 22 percent in 2019, and 29 percent in 2018.

Calculating the Regional Adjustment Under Prospective Assignment

CMS proposes to change how it calculates regional spending for purposes of its regional adjustments by using a window that corresponds to an ACO's assignment window in a given performance year. Specifically, ACOs that select prospective assignment would have CMS use an offset window for regional spending calculations that closely matches the assignment window of October through September of the preceding year. If finalized, this change would take effect beginning for agreement periods starting in 2024.

Under current policy, CMS bases regional spending calculations for purposes of its regional adjustments on a 12-month calendar year that corresponds to the relevant benchmark or performance year. This creates a difference for ACOs that use prospective assignment because the assigned populations are slightly different from the populations used in regional adjustments. Assignment is based on an offset window of October through September of the preceding year to allow time to provide assignment lists at or near the start of the year.

CMS notes in the proposed rule that this creates an unintentional bias for ACOs under prospective assignment, making benchmarks 0.2 percent to 1.9 percent higher than they would have been if the regional adjustment were based on an offset assignment window. The median estimated bias was 1.0 percent. This bias grew under Pathways as more ACOs began receiving regional adjustments.

COVID-19 Effects

CMS did not propose any changes to MSSP's benchmarking methodology to account for the COVID-19 pandemic. However, CMS intends to monitor COVID-19's impact on ACOs to determine if future changes are needed to mitigate any unintended consequences of the pandemic. In 2021, NAACOS asked the agency to allow ACOs the opportunity to elect pre-pandemic years for benchmarks for future agreement periods. We believe that the extreme fluctuation and changes in spending and utilization due to the pandemic would create unfair and unrealistic benchmarks on which to base expectations for future performance.

CMS seeks feedback on its analysis of current data which indicated that spending rebounded in 2021 and that averaging 2020 and 2021 represents a "reasonable basis" on which to base benchmarks. Specifically, the CMS actuary found that spending rebounded in 2021 for ACOs that saw sharp declines in spending in 2020. When benchmarks include both 2020 and 2021 (as it would for ACOs with new performance agreements in 2023) the average of both years represents as "reasonable basis" for which to set future spending targets. Additional update factors such as the current national-regional trend will also help mitigate any impact of COVID-19.

Removing Indian Health Service and Puerto Rican Hospitals

CMS proposes to remove supplemental payments to Indian Health Service and Tribal Hospitals and hospitals located in Puerto Rico from performance year expenditures. CMS already excludes Indirect Medical Education, Disproportionate Share Hospital, and uncompensated care payments from ACOs' expenditure and benchmark calculations to avoid incentivizing ACOs from avoiding patients who receive such care.

Advance Investment Payments

As part of its efforts to grow participation in accountable care models and advance equity, CMS proposes to provide certain MSSP ACOs advance shared savings payments or advance investment payments (AIPs). CMS acknowledges that smaller providers without access to capital and those serving underserved populations may not be able to make the necessary upfront investments to begin an ACO. NAACOS has called for such investments as a strategy to enable ACOs to effectively operate in under-resourced communities, close gaps in health equity, and address social drivers of health (SDOH). Largely modeled after the successes of the ACO Investment Model (AIM), AIPs would provide funding over two years, which would be recouped by CMS through any shared savings earned by the ACO. CMS proposes to limit eligibility to new (not renewing or re-entering) ACOs designated as low revenue and inexperienced with performance-based risk Medicare ACO initiatives. ACOs would be required to apply for AIPs in conjunction with the MSSP application cycle; initial applications would be for a January 1, 2024, start date. CMS notes it would provide preliminary information to applicant ACOs about eligibility to receive AIPs during the MSSP Phase 1 application cycle requests for information.

Duration and use of AIPs

CMS proposes that AIPs would be paid over the first two years of an agreement period and that all AIPs must be spent within the five-year agreement period. Any unspent AIPs must be repaid to CMS at the end of the agreement period in which AIPs were received. As part of the application to receive AIPs, ACOs would be required to submit a plan detailing how AIPs would be spent. ACOs that receive AIPs would be required to publicly report the spend plan, the dollar amount of AIPs received, and itemized spending of AIPs during each performance year. CMS proposes to require that an ACO receiving AIPs must establish and maintain a separate designated account for the deposit and expenditure of all AIPs to promote transparency and enable CMS to monitor ACOs' progress toward implementing the spend plan.

CMS notes that while regulations do not require an ACO to spend shared savings in a particular way, CMS proposes to limit the use of AIPs to investments in three specified categories: increased staffing, health care infrastructure, and the provision of accountable care for underserved beneficiaries, including SDOH strategies. CMS provides examples of permitted uses within each of the three categories on page 46101. CMS also proposes to prohibit the use of AIPs for any expenses such as management/parent company profits, salary augmentation or bonuses, the provision of medical services covered by Medicare, or to pay back shared losses. CMS seeks comment on whether there are additional categories of expenses that should be permitted or prohibited.

Payment Methodology

CMS proposes to provide eligible ACOs with AIPs during the first two performance years of the ACO's participation agreement. AIPs will be comprised of two types of payments: a one-time upfront payment of $250,000 and eight quarterly payments calculated per beneficiary for up to 10,000 beneficiaries. CMS seeks feedback on the proposal to provide a one-time payment of $250,000, as well as alternative approaches to vary the one-time payment based on the number of assigned beneficiaries, risk factors of the ACO's assigned population, or both. AIPs will include quarterly per beneficiary payments, rather than monthly payments, to balance the benefits of predictable cash flow with the administrative costs of calculating payments. CMS proposes to calculate quarterly AIPs prior to the start of each quarter and to disburse quarterly AIPs at the beginning of each of the first eight quarters of the ACO's participation agreement. CMS seeks feedback on the proposed schedule that is detailed in Table 40.

CMS proposes to calculate the quarterly payments by summing the per beneficiary payments for up to 10,000 beneficiaries. The per beneficiary amount will vary for each beneficiary based on a risk factors-based score calculated by CMS. Under the proposal, a beneficiary's risk factors-based score will be informed by dual eligibility status and the Area Deprivation Index (ADI) national percentile ranking of the

census block group of the beneficiary's primary address. This approach is intended to reflect the variable operating costs related to the risk factors of an ACO's assigned beneficiaries and adequately support the provision of accountable care in underserved communities. CMS proposes to calculate an ACO's quarterly payment amounts using the following steps:

1. Determine the ACO's assigned beneficiary population using the latest available assignment list based on the certified ACO participant list for the relevant performance year.
2. Assign each beneficiary a risk factors-based score. Beneficiaries dually eligible for Medicare and Medicaid would be assigned a score of 100 (out of 100). Beneficiaries not dually eligible would be assigned a score (1–100) equal to the ADI national percentile rank of the census block group corresponding to the beneficiary's primary mailing address. For beneficiaries with insufficient data to assign a score, CMS proposes to impute a score of 50.
3. Determine each beneficiaries' payment amount. CMS proposes per beneficiary payment amounts that correspond to the beneficiary's risk factors-based score, detailed in Table 42.
4. Calculate the ACO's total quarterly payment amount by summing the per beneficiary payment amounts for each assigned beneficiary, capped at 10,000 beneficiaries. For ACOs with more than 10,000 assigned beneficiaries, CMS proposes to calculate the total quarterly payment amount based on the 10,000 assigned beneficiaries with the highest risk factors-based scores.

CMS seeks comment on several alternative proposals under the payment methodology. Alternative proposals to determine beneficiaries' risk factors-based scores include:

- Summing the ADI national percentile rank and 25 points if the beneficiary is dually eligible;
- Basing the score on whether the beneficiary is residing in a Health Professional Shortage Area (HPSA) and dual eligibility; or
- Considering whether a beneficiary receives a Part D low-income subsidy in the score calculation.

CMS also seeks feedback on an alternative proposal to consider all an ACO's assigned beneficiaries by averaging the scores of the ACO's assigned beneficiaries rather than using the 10,000 with the highest risk factors-based scores. Under this approach, the per beneficiary payment amount would be scaled based on the relation of the average score to the median.

Compliance, Monitoring, and Recoupment

CMS proposes to monitor the spending of AIPs to ensure appropriate use by comparing the ACO's spend plan against actual spending. The proposed spend plan would not create a benchmark against which the ACO would be held accountable but is intended to increase transparency and allow CMS to track the ACO's progress and any changes to the spend plan. If CMS were to determine that an ACO had used AIPs for a prohibited expense, CMS could immediately terminate the receipt of AIPs and take compliance action.

CMS proposes to monitor for changes in the ACO participant list that could affect the high/low revenue and experienced/inexperienced ACO determination during the course of the agreement period. CMS will notify ACOs if they become high revenue and/or experienced so that the ACO can modify the participant lists prior to the next performance year and remain eligible for AIPs. If an ACO that receives AIPs becomes experienced with performance-based risk or becomes a high revenue ACO, CMS will cease paying AIPs effective the quarter after the ACO achieves the designation. If CMS takes pre-termination action and the ACO continues to be experienced and/or high revenue after a deadline specified by CMS, the ACO would be obligated to repay all spent and unspent AIPs. CMS may immediately terminate the ACO's AIPs without taking pre-termination actions in cases of serious noncompliance or risk of harm to beneficiaries, such as when an ACO ceases to meet eligibility requirements for AIPs, fails to comply with other AIP requirements, or meets grounds for termination under MSSP.

CMS proposes to recoup AIPs from any shared savings earned by the ACO in any performance year until CMS has recouped all AIPs. This includes performance years in subsequent agreement periods. CMS notes that if an ACO does not earn shared savings in any agreement periods, CMS would not recoup any AIPs. However, CMS would recoup any outstanding balance from a re-entering ACO determined to be experienced with performance-based risk. CMS also proposes that if participation is terminated during the agreement period when an ACO receives AIPs, the ACO must repay all AIPs received. CMS seeks comment on all aspects of these proposals.

Quality

CMS proposes several positive changes to the way in which an ACO's quality score contributes to shared savings eligibility. CMS proposes to remove the all-or-nothing approach currently used to determine whether an ACO is eligible to share in any savings it may generate. NAACOS was critical of the initial approach and is pleased that CMS is proposing a more balanced methodology. The regulation does not address the eCQM all-payer approach and timelines. NAACOS is continuing to advocate for CMS to adjust these policies.

Quality Performance Standard and Shared Savings Rates

CMS proposes an alternative quality performance standard that will allow ACOs, who fail to meet the prescribed quality performance standard and earn maximum savings, to be eligible to earn some shared savings. Specifically, beginning with PY 2023, if the ACO achieves a quality performance score equivalent at the 10th percentile or higher on at least one of the four outcome measures in the APM Performance Pathway (APP) measure set, the ACO would share in savings at a lower rate that reflects the ACO's quality performance score. The ACO's final sharing rate would be a scaled by multiplying the maximum sharing rate for the ACO's track/level by the ACO's quality performance score, which includes any health equity bonus points (described below).

The individual measure performance benchmarks are known in advance of the start of the performance period, while the quality performance standard threshold is not known until after the performance period closes. Tying the lower threshold to individual measure performance benchmarks brings some needed certainty to ACOs trying to forecast performance. NAACOS has repeatedly called on CMS to incorporate more transparency into the quality methodologies.

Hypothetical Example

An ACO participating in Basic Track Level B met the MSR to quality for shared savings and had a total quality score (including any health equity bonus points) of 45.

- The total quality score is less than the 30th percentile of MIPS quality performance category scores (the quality performance standard). Thus, the ACO is ineligible for the maximum shared savings rate.
- The ACO did achieve a quality performance score equal the 10th percentile of measure benchmark for one the four outcome measures in the APP measure set. Thus, the ACO is eligible to share in a portion of the savings.
- The shared savings rate is determined based on the ACO's final quality score: 40% (maximum sharing rate for Basic Track Level B) x 45% (final quality score) = final sharing rate of 18%.

Quality Performance Standard Historic Scores

CMS notes it published erroneous weighted scores for MIPS quality performance category percentile scores for 2018 and 2019 in the 2022 MPFS rule. The corrected historic scores for 2018 and 2019 are significantly lower than previously published and will result in more reasonable quality targets for ACOs. The table on the next page shows the prior and corrected scores and includes the newly published 2020 historic scores.

	2018 – 30th percentile	2018- 40th percentile	2019- 30th percentile	2019- 40th percentile	2020- 30th percentile	2020- 40th percentile
Inaccurate (2022 MPFS)	83.9	93.3	87.9	95.7		
Corrected (2023 MPFS Rule)	59.3	70.8	58.0	70.82	63.90	75.59

Shared Losses and Quality Scores – Enhanced Track Participants

CMS proposes to alter the shared loss rate calculation for Enhanced Track ACOs that do not meet the quality performance standard threshold. Beginning in PY 2023, an ACO that meets the existing quality performance standard or that meets the new alternative standard would have shared losses scaled to one minus the product of the maximum sharing rate for the Enhanced Track (75 percent) and the ACO's quality performance score (including any health equity bonus points). The scaled shared loss rate would be subject to a minimum of 40 percent and a maximum of 75 percent. An ACO that fails to achieve the alternative quality performance score (10th percentile or higher on one outcome measure in the APP set) continues to automatically share in losses at the maximum shared loss rate of 75 percent.

Extending eCQM/MIPS CQM Reporting Incentives

CMS previously finalized incentives for ACOs reporting eCQMs or MIPS CQMs in 2022 or 2023. In this rule, CMS proposes to extend the availability of the reporting incentive through 2024. CMS also seeks comment on an alternate proposal to incorporate alternative quality performance standard (discussed above) for those reporting via eCQM or MIPS CQM. As a result, ACOs reporting eCQM/MIPS CQM could achieve the maximum shared savings rate with a quality performance score at the 10th percentile or higher for one of the four outcome measures in 2023 or 2024.

To be eligible to achieve maximum shared savings under the current incentive, the ACO reporting eCQMs/MIPS CQMs must achieve (1) a quality score in 10th percentile or higher for at least one of the four outcome measures in the measure set and (2) a quality performance score in the 30th percentile or higher for one of the remaining five measures in the measure set.

Health Equity Bonus Points for Qualifying ACOs

Beginning in PY 2023, CMS proposes to establish a health equity adjustment that would award bonus points to the quality performance score for ACOs delivering high quality care to underserved populations. The bonus points are only available only to ACOs reporting eCQMs or MIPS CQMs. Specifically, up to 10 health equity bonus points would be added to the total quality score. The number of bonus points earned would be based on the ACO's performance on quality measures and the population served by the ACO (ADI national percentile rank of 85 or higher and dually eligible). Bonus points are added to the quality score, with the total quality score not to exceed 100 points. The bonus points would only be applicable in certain MSSP calculations, such as the alternative quality performance standard determination, some calculations of shared savings/losses, and extreme and uncontrollable circumstances policy calculations.

To determine an ACO's health equity adjustment bonus points, CMS proposes the following steps

1. Calculate the performance measure scaler. The scaler is calculated for each measure, thus an ACO may fall into a difference performance group for each measure. The ACO's measure performance scaler is the sum of the scalers for each of the six measures; the maximum total scaler is 24.
    - Top third performing ACOs awarded scaler of 4
    - The middle third performing ACOs awarded scaler of 2

- The bottom third performing ACOs awarded scaler of zero; ineligible to receive health equity bonus points for this measure

2. Calculate the ACO's underserved multiplier for each ACO. CMS will use the higher value of either:
    - The proportion of an ACO's assigned beneficiary population residing in a census block group with ADI national percentile rank of 85 or higher.
    - The proportion of an ACO's assigned beneficiary population that are dually eligible for Medicare and Medicaid.
    - If an ACO has less than 20 percent of its population in either category, the ACO is ineligible for the health equity bonus points.
3. Calculate the ACO's health equity bonus points. The ACOs' performance measure scaler (up to 24 points) is multiplied by the ACO's underserved multiplier. The bonus points are capped at 10.
    - For example, an ACO that is a high performer across all six measures (performance scaler of 24) with half of the population served being dual-eligible beneficiaries (underserved multiplier of 0.5) would have health equity bonus points of 12. Therefore, the bonus points would be capped at 10.

MSSP Quality Measure Changes

CMS does not propose changes to the MSSP quality measure sets for PY 2023. However, CMS does propose to change the name of the All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS measure to Measure 484: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions. Please refer to Table 52 and 53 in the proposed rule for a list of measures included in the APM Performance Pathway (APP) measure set for PY 2023.

Under the Merit-Based Incentive Payment System (MIPS), CMS proposes to increase the quality data completeness standard from 70 percent to 75 percent in 2024. If finalized this would also apply to ACOs reporting eCQMs/MIPS CQMs.

Request for Information: Adding Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health Measures, and Addition of New CAHPS for MIPS Survey Questions

CMS seeks comment on the potential future inclusion of two new measures in the MSSP quality measure set (see Table Group A of Appendix 1 of the proposed rule for full measure details):

- Screening for Social Drivers of Health which assesses the percentage at which providers screen adult patients for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety.
- Screen Positive Rate for Social Drivers of Health. The Screening for Social Drivers of Health measure which assess the percentage of patients who screen positive for any of the social risk factors included in the prior measure.

CMS also seeks comment on the potential future question for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey that addresses health disparities and patient experience with discrimination. Specifically, CMS is seeking input on the question "In the last six months, did anyone from a clinic, emergency room, or doctor's office where you got care treat you in an unfair or insensitive way because of any of the following things about you?" Potential responses would include health condition, disability, age, culture, sex (including sexual orientation and gender identify), and income.

Finally, CMS seeks input on the potential future questions for the CAHPS for MIPS Survey that address price transparency. These questions would build upon the goals of the No Surprises Act, improving transparency and oversight of drug and medical costs and providing patients additional information on which to base their healthcare decisions.

Quality Benchmark Changes

CMS notes the last set of Web Interface benchmarks were established for PY 2020 and were used to score the Web Interface measures for PY 2021. In this rule CMS clarifies it will establish benchmarks for the Web Interface measures for PYs 2022, 2023 and 2024 using previously established benchmark policies. CMS inadvertently omitted inclusion of this policy when the agency extended the Web Interface reporting option for ACOs.

For PYs 2022 and 2023 CMS proposes to use flat percentage benchmarks for two measures. Note this policy is retroactive for 2022. The measures are: Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention (Quality ID# 226) and the Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID 134). As a result, ACOs would be scored on eight out of 10 CMS Web Interface measures for the 2022. This differs from previous policy where CMS indicated ACOs would be scored on seven out of 10 Web Interface measures for 2022.

Extreme and Uncontrollable Circumstances Policy

CMS proposes changes to the Extreme and Uncontrollable Circumstances policy to align with other proposals in this rule. Under the Extreme and Uncontrollable Circumstances policy, an affected ACO that fails to report quality data or reports but fails to meet data completeness or case minimum requirements will have its quality score set to the quality performance standard (i.e., able to achieve maximum shared savings). To align with the alternative quality performance standard, CMS proposes that an ACO that meets this standard would continue to qualify for the maximum sharing rate for its track/level rather than receiving a sharing rate scaled based on the ACO's quality performance.

MIPS Errors and ACO Financial Determinations

MSSP shared savings and loss calculations are tied to whether an ACO meets the established quality performance standard, which is developed based on MIPS quality scores. CMS notes that it has sole discretion to make corrections to a prior performance year's MSSP ACO financial determinations as a result of corrections made to MIPS quality performance category scores.

Typically, CMS provides MSSP financial reconciliation reports in August of the year following the performance year, with payments to ACOs initiated in September. The timeline for conducting MIPS targeted review may extend past the date CMS issues financial reconciliation reports. Accordingly, CMS may learn of MIPS quality performance calculation errors after MSSP initial financial performance determinations are issued. CMS notes it is considering an approach in which CMS would reopen initial MSSP financial determinations to account for changes to MIPS quality performance scores. Reopening these determinations could impact whether an ACO is eligible for shared savings and the amount of shared savings or losses. In these cases, CMS notes it would potentially adjust future financial performance determinations to account for changes as a result of MIPS quality score changes. This approach would not alter the current requirement that ACOs repay shared losses within 90 days after notification of the initial determination of shared losses.

Beneficiary Assignment

CMS proposes to revise the definition of primary care services it uses to assign beneficiaries to ACOs. CMS proposes the addition of the following codes:

- GXXX2: for prolonged nursing facility services furnished by a physician or non-physician practitioner (NPP) for each additional 15 minutes of time beyond the total time for CPT codes 99306 or 99310, both of which are already included in the MSSP assignment list.

- GXXX3: prolonged home or residence E/M services furnished by a physician or NPP for each additional 15 minutes of time beyond the total time for CPT codes 99345 or 99350, both of which are included in the MSSP assignment list
- GYYY1 and GYYY2: chronic pain management (CPM)

CMS posits that GXXX2 and GXXX3 represent longer time periods for services already included in the definition of primary care services. Including CPM would remain consistent with care management services included in the MSSP assignment list, CPM is analogous to Chronic Care Management (CCM) and Principal Care Management (PCM) services (99424 and 99425).

CMS also proposes to adopt changes to the guidelines for E/M services furnished in a patient's home (99341 through 99350) to include services provided in assisted living facilities, group homes, custodial care facilities, and residential substance use treatment facilities by omitting the reference to "for claims identified by place of service modifier 12" from the code descriptions. CMS believes it is no longer necessary to specify place of service 12 because the codes have been revised to include multiple places of services that could be considered the patient's home other than a private residence.

Under the CAA of 2021, Congress established a new rural Medicare provider type, Rural Emergency Hospitals (REHs). CMS notes that REHs will submit claims in a similar manner to hospital outpatient departments paid under the Outpatient Prospective Payment System (OPPS) and therefore CMS is not proposing special policies regarding the treatment of services furnished in REHs for purposes of MSSP beneficiary assignment.

Finally, CMS proposes new policies for using CMS Certification Numbers (CCNs) in beneficiary assignment. CCNs are used to identify certain provider types (Federally Qualified Health Centers, Rural Health Centers, Electing Teaching Amendment hospitals, and Critical Access Hospitals) that have enrolled under an ACO participant TIN. CMS uses the CCN as the identifier for these entities since the TINs for these provider types are not included in claims files. Under the current process, CCN changes are only identified during the application process or annual change request cycle. Changes to the CCNs enrolled under ACO participant TINs during the performance year are not captured.

CMS found that an estimated 42,000 additional beneficiaries would have been assigned to MSSP ACOs in PY 2020 if CMS had included newly enrolled CCNs for purposes of assignment. Therefore, beginning with PY 2023, CMS proposes to determine the CCNs enrolled under ACO participant TINs prior to the start of the performance year and periodically during the performance year. CCNs that enroll during the performance year would be reflected in program operations including assignment, revenue and expenditure calculations, and financial reconciliation. CMS will include all CCNs with active or deactivated enrollment status in determining assignment for the performance year. CMS intends to develop a mechanism for reporting to ACOs all CCNs used in assignment and program operations on a periodic basis. This policy would only apply to ACOs that have selected preliminary prospective assignment with retrospective reconciliation.

Administrative Burden Reduction

Marketing Material Requirements

CMS currently requires that any marketing materials and activities used by an ACO and its participants or providers/suppliers must be submitted to CMS prior to use. If the ACO certifies compliance with all marketing requirements and CMS approves the marketing materials or activities, they may be used five business days following submission. Citing the operational burden imposed on and the time and resources expended by CMS to review submitted marketing materials, CMS proposes to remove the

requirement that ACOs must submit marketing materials to CMS before. Instead, CMS will require that ACOs provide marketing materials and activities only upon request.

Beneficiary Notification Requirements

CMS currently requires that ACO participants post signs and provide and annual written notice to beneficiaries that its providers are participating in the MSSP. ACOs that have selected preliminary prospective assignment must furnish the written notice to all FFS beneficiaries, ACOs that have selected prospective assignment must furnish the notice to each prospectively assigned beneficiary. To improve the beneficiary notice and promote program transparency, CMS proposes several changes to the beneficiary notification requirements. CMS proposes to:

- Clarify that beneficiary notification signs must be posted in all ACO participant facilities, regardless of whether primary care services are provided in each facility.
- Reduce the frequency of the annual standardized written notices from once per performance year to once per five-year agreement period. The standardized written notice must be furnished prior to or at the first primary care service visit during the first performance year in which the beneficiary receives a primary care service from an ACO participant.
- Establish a new follow-up written or verbal communication that must occur no later than the beneficiary's next primary care service visit or 180 days after the standardized written notice was provided. ACOs would be required to track and document how the follow-up communication is implemented and make this documentation to CMS upon request. CMS indicates it will grant flexibility to an ACO as long as it includes meaningful opportunity for beneficiaries to engage with a representative of the ACO or ACO participant. CMS believes this will reduce beneficiary confusion and improve beneficiary comprehension. CMS seeks comment on the proposed frequency of the notification and whether the proposals will reduce net burden and mitigate beneficiary confusion.

Streamline SNF Three-Day Rule Waiver Application Review Process

ACOs participating or applying to participate in performance-based risk tracks (BASIC C through E or Enhanced) may request to use the Skilled Nursing Home (SNF) Three-Day Rule Waiver. The current application process requires ACOs to submit a SNF affiliate list with agreements and three narratives describing how the ACO will implement the waiver. This includes a communication plan, a care management plan, and a beneficiary evaluation and admission plan. CMS is proposing to remove the requirement to submit the plan narratives and allow ACOs to attest that they have them in place prior to approval of the SNF waiver. An ACO must make the plans available to CMS upon request.

Recognize ACOs Structured as OHCAs for Data Sharing Purposes

While most ACOs function as business associates of their covered entity ACO participants, some ACOs may choose to operate as organized health care arrangements (OHCAs), another type of entity that is recognized under HIPAA under the authority of The HHS Office for Civil Rights (OCR) and the Office of the National Coordinator for Health Information Technology (ONC). ACOs that operates as OHCAs can share protected health information (PHI) among the covered entities in the OHCA. Accordingly, CMS is proposing to modify the MSSP data sharing regulations to specify that ACOs acting as OHCAs may request aggregate reports and beneficiary identifiable claims data from CMS. CMS states its intention to update the data sharing regulations to reflect how ACOs may be structured and provide flexibility with respect to the different arrangements permitted under the Health Insurance Portability and Accountability Act (HIPAA) for purposes of data sharing.

PHYSICIAN PAYMENT AND POLICY CHANGES

Payment Update
CMS proposes a CY 2023 Medicare conversion factor (CF) of $33.0775, a decrease of 4.42 percent from the 2022 CF rate of $34.6062. The update reflects the expiration of the one-time 3 percent increase in payment provided by the CAA and a -1.5 percent budget neutrality adjustment.

E/M Visits
In recent years, CMS has overhauled of E/M visits, updating coding and payment to better reflect the current practice of medicine and reduce administrative complexity. Generally, CMS has adopted revisions by the American Medical Association Current Procedural (AMA CPT) Editorial Panel to based E/M visits on time spent and medical decision-making (MDM). For CY 2023, CMS proposes to similarly update "Other E/M visits" which include inpatient and observation visits, emergency department visits, nursing facility visits, domiciliary or rest home visits, home visits, and cognitive impairment assessment. Additionally, CMS proposes prolonged visit codes for inpatient/observation visits, nursing facility visits, and home or resident visits. Table 18 provides details on these codes

Behavioral Health
CMS includes a series of new behavioral health proposals aimed at advancing the agency's 2022 Behavioral Health Strategy to address the national mental health crisis. CMS proposes to:

- Create new payments for chronic pain management and treatment (CPM) bundles; Healthcare Common Procedure Coding System (HCPCS) code GYYY1 (CPM monthly bundle) and GYYY2 (add-on code for each additional 15 minutes of CPM services).
- Amend direct supervision requirement under "incident to" regulation to allow behavioral health services to be furnished under the general supervision of a physician or NPP.
- Create a new G-code GBHI1 for general behavioral health integration (GBHI) performed by clinical psychologists or clinician social workers who are not authorized to bill under the current E/M code for GBHI services.
- Increase payment rates to opioid treatment programs and to expand telehealth access to medication assisted treatments.

Rural Health Clinics and Federally Qualified Health Centers
CMS makes conforming proposals to add new care management codes for CPM and GBHI, as described above. CMS proposes to include CPM services in the general care management HCPCS code G0511 and clarifies that when clinical psychologists and clinical social workers provide services described in GBHI1 in an RHC or FQHC, they can bill G0511. CMS also proposes conforming technical to implement telehealth provisions of the CAA (2021 and 2022), including the 151-day extension of non-in-person visits for all RHC and FQHC mental health visits and delaying the in-person requirements for tele-mental health visits.

Telehealth and Other Services Involving Communications Technology

Covered Telehealth Services
CMS proposes to add more than 50 codes to the Medicare Telehealth Services List temporarily through the end of 2023. The full list of these services can be found on Table 8 of the proposed rule. CMS created this temporarily covered list, Category 3 services, during the COVID-19 Public Health Emergency (PHE) to give regulators more time to study whether services can be permanently added to the Medicare's telehealth list at a later date. CMS is not proposing the length of time it will temporarily cover these additional services; CMS indicates it will reconsider this policy should the length of the PHE change.

PHE-Related Flexibilities

CMS proposes to extend PHE-related telehealth flexibilities for 151 days following the expiration of the PHE, per the CAA of 2022. This includes an expansion of originating sites, eligible practitioners, a delay in in-person requirements for tele-mental health services, and coverage of audio-only telehealth services. CMS makes a special reference to telephone-based or audio-only E/M visits (99441, 99442, and 99443), which will be assigned a bundled status at the end of the PHE and subsequent 151-day extension. CMS notes that live, audio-video continues to be the appropriate standard for telehealth services.

Remote Monitoring

CMS proposes to create four new HCPCS G-codes for remote therapeutic monitoring services (GRTM1-GRTM4). The newly proposed codes are intended to increase patient access and reduce supervisory burden by allowing "incident" to billing by auxiliary staff under general supervision. Summaries of the codes are provided in Table 28 of the proposed rule.

CMS proposes to create a code for cognitive behavioral therapy monitoring (989X6), which would cover therapy adherence, therapy response, and device set-up to monitor cognitive behavioral therapy for 30 days. CMS indicates it will work with Medicare Administrative Contractors to better understand devices and costs and review claims for payment under this new code.

QUALITY PAYMENT PROGRAM

Merit Based Incentive Payment System (MIPS) Proposals

CMS proposes minimal MIPS changes for ACOs in 2023. MIPS performance category weights will remain the same for ACOs subject to MIPS.

MIPS Payment Adjustments

CMS proposes to maintain a 75-point performance threshold for PY 2023, which corresponds to 2025 payments. As a reminder, the no exceptional performance bonus has expired for PY 2023 (2025 payments) and beyond. Figure 4 on page 46322 of the proposed rule provides an illustrative example of MIPS payment adjustment factors based on the proposed performance threshold for the 2025 MIPS payment year, however these are illustrative examples only.

Promoting Interoperability

CMS proposes several changes to the Promoting Interoperability performance category scoring as well as objectives and measure requirements for 2023, outlined in Tables 86 and 88.

Requests for Information Related to Digital Quality Measurement

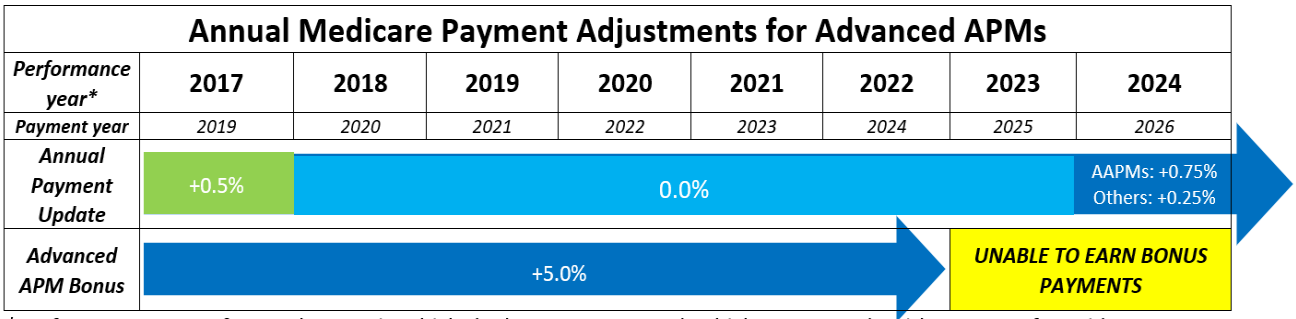
The proposed rule also includes a request for information on use of the Trusted Exchange Framework and Common Agreement (TEFCA) and on data standardization approaches to transition to Fast Healthcare Interoperability Resource (FHIR) electronic Clinical Quality Measure (eCQM) reporting, as an initial step in the CMS transition to digital quality measurement.

Advanced Alternative Payment Models (APMs)

As a reminder, PY 2022 is the final year to earn the 5 percent advanced APM incentive payment that was included in the Medicare Access and Chip Reauthorization Act (MACRA). Under current law, qualifying APM participant (QP) thresholds are also set to increase for PY 2023 to 75 percent for the payment amount method and 50 percent for the patient count method. The partial QP thresholds will be 50 percent for the payment amount method and 35 percent for the patient count method. Beginning with PY 2024 (payment year 2026), QPs will earn a higher annual update of 0.75 percent compared to the 0.25

percent automatic update for clinicians in MIPS. The chart below providers an overview of the current QPP incentive payment structure established under MACRA.

NAACOS is strongly advocating Congress to extend the Advanced APM incentive payment and give CMS the authority to set QP thresholds. These actions must be taken by Congress. NAACOS has been working with lawmakers to build support for the bipartisan Value in Health Care Act of 2021 (H.R. 4587), that provides a six-year extension of the incentives. NAACOS has created a summary of the bill.



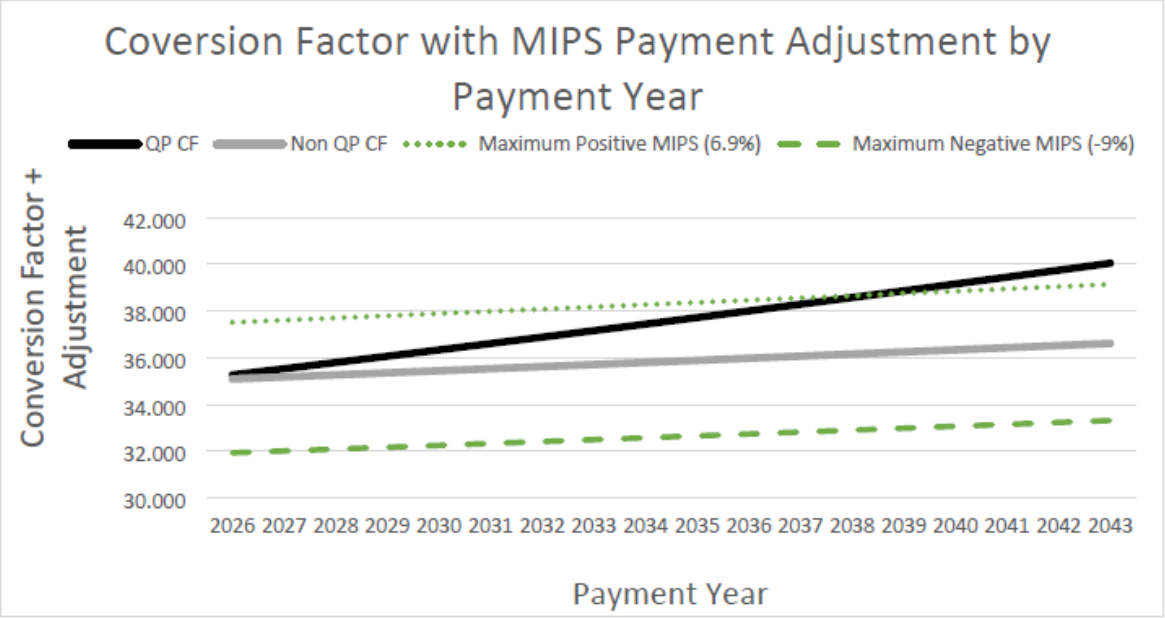
**Performance year refers to the year in which the bonus was earned, which corresponds with payment for said bonus two years later*

CMS proposes several modifications to the Advanced APM regulations:

- CMS clarifies that that the requirement for Advanced APMs payments to be based on quality measures can be met using a single quality measure that meets the criteria under both current regulation 414.1415(b)(2) and (b)(3). That is, the measure must be evidence-based, consensus-endorsed or on the MIPS list and be an outcome measure.
- CMS proposes to make permanent the 8 percent minimum for the generally applicable nominal risk standard for Advanced APMs.
- CMS proposes to move up the cutoff date for QPs to update their information for the appropriate TINs following non-payment of incentives from November 1 to September 1, or 60 days from the date on which the initial round of payments are made.

In the proposed rule, CMS expresses concern that the substantial difference between the QP conversion factor and maximum positive payment adjustment available under MIPS might affect the willingness of eligible clinicians to participate in Advanced APMs for several years to come. CMS also projects that increasing QP thresholds will result in nearly 100,000 fewer QPs in 2023. CMS projects that there will be between 144,700 and 186,000 QPs during PY 2023, which is a significant drop from the 225,000 to 290,000 estimated QPs for PY 2022. This could also impact the availability and distribution of funds in the budget neutral MIPS payment pool because many Advanced APM would likely be high performers under MIPS. As illustrated in Figure 5 (reproduced below), the QP conversion factor that will be compounded annually is not expected to catch up to maximum MIPS bonuses until after CY 2038. The agency issued a request for information to learn more from stakeholders about their participation plans going forward.

FIGURE 5: PFS Conversion Factors vs. Maximum MIPS Payment Adjustments*



*This graph depicts the PFS conversion factors that would apply for each year given the annual updates as specified in current statute, and does not otherwise depict an estimate of PFS payment rates for future years.

Request for Information: QPP Incentives Beginning in PY 2023

The agency is seeking public comments on the following:

- What are your primary considerations going forward as you choose whether to participate in an Advanced APM or be subject to MIPS reporting requirements and payment adjustments? What factors are the most important as you make this decision?
- If you are participating in an Advanced APM now and have been or could be a QP for a year, will the end of the 5 percent lump-sum APM Incentive Payments beginning in the 2025 payment year (associated with the 2023 QP Performance Period) cause you to consider dropping your participation in the Advanced APM, which would mean forgoing QP determinations, thereby ensuring you are subject to MIPS reporting requirements and payment adjustments?
- Going forward, attaining QP status for a year through sufficient participation in one or more Advanced APMs will enable an eligible clinician to, for a year: (1) continue receiving any financial incentive payments available under the Advanced APM(s) in which they participate, subject to the terms and conditions applicable to the specific Advanced APM(s); (2) be paid under the PFS in the payment year using the a higher QP conversion factor (0.75 percent rather than 0.25 percent) beginning in payment year 2026; and (3) not be subject to MIPS reporting requirements or payment adjustments. Do these three conditions provide sufficient incentives for you to participate in an Advanced APM, or would you instead decide to be subject to MIPS reporting requirements and payment adjustments?
- Are there other advantages of MIPS participation that might lead a clinician to prefer MIPS over participation in an Advanced APM, such as: (1) quality measurement that may be specific to a particular practice area or specialty area; or (2) the desire for more precise accountability through public reporting of quality measure performance in the future?

Request for Information: Potential transition to Individual QP Determinations Only

Under current policy, QP determinations for most eligible clinicians participating in Advanced APMs are made at the APM entity level. For the All-Payer Combination Option, eligible clinicians may request that the determination be made at the individual or APM entity level. CMS is requesting public comment on

the idea of transitioning away from an APM entity level QP determination and instead making QP determinations at the individual eligible clinician level for all eligible clinicians in Advanced APMs. CMS believes this future policy change would reduce the practice of APMs removing specialists from their participation lists, increase the number of eligible clinicians who are determined to be QPs, and eliminate eligible clinicians who become QPs for a year only because of their affiliation with an APM entity that achieves QP status.