NAACOS Analysis of the CY 2024 Proposed Medicare Physician Fee Schedule

Executive Summary

On July 13, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2024 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 affecting 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.

Comments to CMS in response to the proposed rule are due on September 11 and may be submitted on the regulations.gov website. 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. NAACOS will provide draft comments ahead of the deadline. CMS will review comments and issue a final rule later this year, typically by November 1.

Medicare Physician Payment Proposals

- Decreases the Medicare conversion factor from $33.89 to $32.75 for 2024.
- Implements an evaluation and management visit add-on code for complexity (G2211); this code was previously delayed by Congress. CMS is proposing implementation with modifications.
- Creates new codes for community health integration services and social determinants of health (SDOH) risk assessment.

MSSP Proposals

Assignment Methodology:

- Adds a third step to the assignment process in 2025 that would expand the assignment window for a physician visit to two years; this allows the assignment methodology to better account for beneficiaries who primarily receive services from a nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS).
- Adds several new codes to the definition of primary care services used in ACO assignment.

Benchmarks and Risk Adjustment:

- Proposes to effectively eliminate the negative regional adjustment.*

- Modifies its use of the CMS-Hierarchical Condition Code (HCC) risk adjustment model to account for the new model version starting in 2024 by using the same model version in benchmark and performance years.*
- Phases in new risk model version over three years for all ACOs starting next year.*
- Caps the risk score growth in an ACO's region for agreements beginning in 2024, making the cap on the ACO and its region symmetrical.*
- Seeks comment on potential further refinements to the Accountable Care Prospective Trend and increasing the prior savings adjustment.*

Quality:

- Creates a new quality reporting option for MSSP ACOs; the Medicare Clinical Quality Measures reporting option would require ACOs to report only on Medicare beneficiaries, providing flexibility with the previous all-payer reporting requirement.*
- Changes the Quality Performance Standard calculations to use historical data.*
- Adjusts policies related to quality scoring requirements for suppressed measures and makes changes to Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures.
- Removes Certified Electronic Health Record Technology (CEHRT) threshold requirements for certain MSSP ACOs.
- Solicits comments on Merit-based Incentive Payment System (MIPS) Value Pathways quality reporting for specialists in MSSP ACOs.

Other:

- Seeks comments on the potential for an Enhanced Plus Track, which would allow higher levels of risk in MSSP.*
- Modifies policies for advance investment payments (AIPs) to allow ACOs receiving AIPs to transition to a two-sided risk model under the Basic Track in Performance Year (PY) Three, to allow an exception to the recoupment policies for ACOs that early renew, to permit reconsideration of quarterly payment calculations, and to update policies related to early termination and reporting.*
- Revises MSSP eligibility requirements and clarifies definitions for experience with performance-based risk.
- Seeks comments on ways to increase collaboration between ACOs and community-based organizations (CBOs).

Quality Payment Program Proposals

- Makes all advanced alternative payment model (APM) qualifying participant (QP) determinations at the individual level only, instead of the APM entity level and modifies the attribution methodology.
- Makes updates to MIPS requirements for APMs.
- Increases the MIPS performance threshold from 75 to 82 points for PY 2024.

*Denotes policies for which NAACOS has advocated.

PHYSICIAN PAYMENT

Payment Update

CMS proposes a CY 2024 Medicare conversion factor (CF) of $32.75, a decrease of 3.34 percent from the 2023 CF rate of $33.89.

E/M Visits

In recent years, CMS has overhauled evaluation and management (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 Terminology (AMA CPT) Editorial Panel to base E/M visits on time spent and medical decision-making (MDM). In the CY 2021 MPFS final rule, CMS refined the O/O E/M visit complexity add-on code, GPC1X (which was replaced by HCPCS code G2211), to describe intensity and complexity inherent to O/O E/M visits associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex condition. The Consolidated Appropriations Act of 2021 delayed implementation of this code for three years.

CMS is proposing to implement the complexity add-on code, HCPCS code G2211, beginning January 1, 2024. The code cannot be reported when the E/M service is reported with a payment modifier (e.g., modifier-25) that denotes a separately billable E/M service by the same practitioner on the same day of a procedure or service that already accounts for complexity.

CMS is also generally seeking comments on how it might improve the accuracy of valuation for services with greater specificity, more regularly, and comprehensively.

Telehealth

CMS proposes to add codes for health and well-being coaching services on a temporary basis and for SDOH risk assessments on a permanent basis to the Medicare Telehealth Services List effective January 1, 2024. The agency is also proposing a new process to analyze requests for additions to the telehealth services list. CMS also proposes to implement several provisions of the Consolidated Appropriations Act of 2023:

- Temporary expansion of telehealth originating sites
- Expansion of the definition of telehealth practitioner to include occupational therapists, physical therapists, speech-language pathologists, and audiologists
- Continuation of telehealth for rural health clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- Delaying the in-person visit requirement for mental health telehealth services
- Continuation of coverage and payment for telehealth services (including audio-only) included on the Medicare Telehealth Services List as of March 15, 2020, through December 31, 2024

Behavioral Health

CMS makes several proposals to implement provisions of the Consolidated Appropriations Act of 2023:

- Payment of services billed by marriage and family therapists (MFTs) and mental health counselors (MHCs). These providers will be able to enroll in Medicare after publication of the final rule.
- New HCPCs codes for psychotherapy for crisis services
- Updates to the hospice Conditions of Participation (CoPs) to allow social workers, MHCs, or MFTs to serve as members of the interdisciplinary group

CMS proposes additional changes to increase the valuation for timed behavioral health services and allow Health Behavior Assessment and Intervention (HBAI) services to be billed by clinical social workers, MFTs, and MHCs, in addition to clinical psychologists.

Services Addressing Health-Related Social Needs

CMS is proposing to pay separately for services that address health-related social needs. This aligns with several administration priorities related to health equity. Specifically, CMS is proposing to pay for:

- Community Health Integration services performed by certified or trained auxiliary personnel, which may include a community health worker (CHW), incident to the professional services and under the general supervision of the billing practitioner.
    - GXXX1 – Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visits (see page 241 of the display copy for full description of services)
- GXXX2 – Community health integration services, each additional 30 minutes per calendar month (List separately in addition to GXXX1)Principal Illness Navigation Services when certified or trained auxiliary personnel under the direction of a billing practitioner, which may include a patient navigator or certified peer specialist, are involved in the patient's health care navigation as part of the treatment plan for a serious, high-risk disease expected to last at least 3 months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death.
    - GXXX3 Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month, in certain activities (see page 264 of the display copy for the full list of activities)
    - GXXX4 – Principal Illness Navigation services, additional 30 minutes per calendar month (List separately in addition to GXXX3).
- Social Determinant of Health Risk Assessment, a review of the individual's SDOH or identified social risk factors that influence the diagnosis and treatment of medical conditions.
    - GXXX5, Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months.

- CMS is proposing to add SDOH risk assessment as an optional element of the Annual Wellness Visit, with additional payment.

MEDICARE SHARED SAVINGS PROGRAM

Quality Performance Standard and Other Reporting Requirements

CMS proposes to establish an additional reporting type for MSSP ACOs; the Medicare Clinical Quality Measures (CQMs) option would be effective for PY 2024 and subsequent years, as determined by CMS. Medicare CQMs would require reporting of MIPS CQMs, with reporting limited to Medicare fee-for-service beneficiaries eligible for Medicare CQMs as defined at §425.20 (see more information below). CMS notes its continued commitment to its long-term goal of ACOs reporting all payer/all patient measures and emphasizes this is meant to be a transitional reporting option. CMS does not propose changes to the current timeline to retire the Web Interface in PY 2025 or propose any changes to the electronic clinical quality measures (eCQMs) reporting option. ACOs would continue to have the option to report eCQMs, MIPS CQMs, or Web Interface measures in 2024. Table 25, Proposed APM Performance Pathway (APP) Reporting Requirements and Quality Performance Standard for PY 2024 and Subsequent Performance Years on page 537 of the display copy outlines reporting criteria as proposed for ACOs.

Medicare CQMs

According to CMS, a Medicare CQM is "essentially a MIPS CQM reported by an ACO under the APM Performance Pathway (APP) on only the ACO's Medicare fee-for-service beneficiaries, instead of its all payer/all patient population." CMS proposes to define a beneficiary eligible for Medicare CQMs at §425.20 as a beneficiary identified for purposes of reporting Medicare CQMs who is either of the following:

A Medicare fee-for-service beneficiary (as defined at §425.20) who

- Meets the criteria for a beneficiary to be assigned to an ACO described at §425.401(a); and
  - Had at least one claim with a date of service during the measurement period from an ACO professional who is a primary care physician or who has one of the specialty designations included in §425.402(c); or who is a PA, NP or CNS
- A Medicare fee-for-service beneficiary who is assigned to an ACO in accordance with §425.402(e) because the beneficiary designated an ACO professional participating in an ACO as responsible for coordinating their overall care (voluntary alignment)

Therefore, through the definition of a beneficiary eligible for Medicare CQMs, CMS is further limiting the reporting of Medicare CQMs to Medicare fee-for-service beneficiaries who meet the ACO assignment criteria and had at least one claim with a date of service during the measurement period from an ACO professional who is a primary care physician or has one of the specialty designations noted in the second step of the ACO assignment methodology at §425.402(c); or who is a PA, NP or CNS, as well as beneficiaries voluntarily aligned to ACOs.

This limits reporting to a population similar to that used in the Web Interface and therefore reduces concerns with specialty providers reporting on primary care measures. This approach also eliminates equity concerns NAACOS raised regarding the all payer/all patient approach that compares quality scores without concern to payer mix. NAACOS is pleased to see CMS make these proposed changes and will continue to stress to CMS the issues with moving to an all payer/all patient approach to quality reporting for ACOs.

Data Completeness for Medicare CQMs
CMS proposes the data completeness criteria for Medicare CQMs as follows:

- At least 75 percent for PY 2024, 2025 and 2026
- At least 80 percent for PY 2027

CMS also provides conflicting language in the rule indicating that ACOs must report on all Medicare patients meeting Medicare CQM criteria; NAACOS is seeking clarification on this.

Data Aggregation Instructions for Medicare CQMs
CMS notes the agency would expect an ACO reporting Medicare CQMs to aggregate patient data for beneficiaries eligible for Medicare CQMs, as proposed at §425.20, across all ACO participants. The ACO would then match the aggregated patient data with each Medicare CQM specification to identify the eligible population for each measure. CMS notes the ACO's aggregated ACO submission must account for 100 percent of the eligible and matched patient population across all ACO participants – this conflicts with the data completeness standards noted elsewhere in this regulation; NAACOS is seeking clarification on this point.

CMs notes ACOs that include or are composed solely of FQHCs or RHCs must report quality data on behalf of the FQHCs or RHCs that participate in the ACO. While FQHCs or RHCs that provide services that are billed exclusively under FQHC/RHC payment methods are exempt from reporting traditional MIPS, those participating in APMs such as the MSSP are considered APM Entity groups for purposes of the APM Scoring Standard and should be included in quality reporting.

CMS will provide ACOs with a list of beneficiaries eligible for Medicare CQMs within the ACO annually at the beginning of the quality data submission period. Because CMS would not have full claims run-out on performance year data prior to the start of the quality data submission period, the list of beneficiaries would not be considered a complete list. ACOs would need to ensure all beneficiaries that meet applicable Medicare CQM specifications and also meet the definition of a beneficiary eligible for Medicare CQMs under §425.20 are included in the ACO's eligible population/denominator for reporting each measure. CMS anticipates sharing the following information along with technical assistance to ACOs when reporting Medicare CQMs:

- Gender
- Beneficiary identifier
- DOB (and death if applicable)
- Chronic condition subgroup
- NPIs of the top three frequented providers in the ACO

- Health status information (e.g., risk profile)

Benchmarks and Other Notes on Medicare CQMs
CMS will allow ACOs reporting Medicare CQMs to earn equity bonus points, however those reporting Medicare CQMs will not be eligible for the reporting incentive applicable to eCQM/MIPS CQM reporting.

For PY 2024 and 2025 CMS proposes to score Medicare CQMs using performance period benchmarks since they will lack any historical data. For PY 2026 and subsequent years CMS will transition to using historical benchmarks when baseline period data are available.

ACO Quality Measure Changes

CMS does not propose any changes to the quality measure set used for ACOs for PY 2024.

- Refer to Table Group E of Appendix 1 of the proposed rule for changes to measure specifications for PY 2024.

For PY 2025, CMS proposes to align the quality measure set with the new Universal Foundation measure set CMS is promoting across quality programs. This measure set will also be included as a Value in Primary Care MIPS Value Pathways (MVP). This will include three new measures for ACOs:

- Adult immunization status
- Initiation and engagement of substance use disorder treatment
- Screening for social drivers of health

See Tables 26–28 in the proposed rule for a list of measures proposed for PY 2024, PY 2025, and subsequent years.

Changes to the Quality Performance Standard

CMS proposes changes to the calculation of the Quality Performance Standard, which must be met to be eligible for maximum shared savings. CMS proposes:

- To use a three PY rolling average with a lag of one performance year to calculate the Quality Performance Standard for PY 2024 and subsequent years (e.g., for 2024 CMS would use PY data for PY 2020 through PY 2022)
- To provide ACOs with the Quality Performance Standard amount prior to the start of the performance year.

NAACOS has long advocated for CMS to provide more transparency, and we are pleased to see CMS make these proposed changes. The move to a three-year rolling average instead of using the performance year data to calculate the Quality Performance Standard will bring more stability to scores and allow ACOs to see their targets prior to the start of the performance year, which is anticipated in December. Table 29 in the proposed rule outlines the Quality Performance Category Scores using current and proposed methodologies.

Proposal to Apply a Shared Savings Program Scoring Policy for Excluded/Suppressed APP Measures

CMS proposes to apply a policy for excluded/suppressed quality measures for ACOs specifically. In circumstances when the ACO's total achievement points used to calculate the quality score for the performance year was reduced due to measure exclusion/suppression policies in MIPS, CMS will award the higher of an ACO's own quality performance score or the 40th percentile MIPS Quality performance category score when determining whether the ACO meets the quality performance standard required to share in savings.

To be eligible, an ACO must:

- Report all required measures under the APP and
- Meet data completeness requirements.

This policy would begin in PY 2024 and is a favorable change for ACOs. NAACOS is pleased CMS is proposing this policy as instability in the measure set in recent years has been a growing problem for ACOs.

Requiring Spanish Language Administration of CAHPS for MIPS Survey

Beginning with the 2024 survey administration, CMS proposes to require MIPS eligible clinicians and ACOs to contract with a CMS-approved survey vendor to administer the CAHPS for MIPS Survey in both English and Spanish for Spanish-preferring patients, using the procedures detailed in the CAHPS for MIPS Quality Assurance Guidelines. This could increase survey participation and therefore potentially raise scores for ACOs.

Modifications to the Health Equity Quality Adjustment

CMS proposes revisions to calculations used to award health equity quality bonus points. CMS proposes:

- To remove beneficiaries who do not have a numeric national percentile rank available for Area Deprivation Index from the health equity adjustment calculation for PY 2023 and subsequent years (will not appear in the numerator or denominator) and
- To modify the calculation of the proportion of assigned beneficiaries dually eligible for Medicare and Medicaid and the calculation of the proportion of assigned beneficiaries enrolled in the Low Income Subsidy to use the number of beneficiaries rather than person years, starting in PY 2024.

These changes are proposed to bring greater consistency between the calculation of the proportion of ACOs' assigned beneficiaries residing in a census block group with an Area Deprivation Index national percentile rank of at least 85 and the proportion of the ACOs' assigned beneficiaries who are enrolled in a Medicare Part D Low Income Subsidy or are dually eligible for Medicare and Medicaid.

Proposals to Align CEHRT Requirements for Shared Savings Program ACOs with MIPS

CMS seeks to streamline CEHRT threshold requirements for ACOs and align with the MIPS Promoting Interoperability requirements by proposing to sunset the MSSP CEHRT threshold requirements starting

in PY 2024. Instead, any requirements applicable to MIPS eligible clinicians reporting Promoting Interoperability (PI) category objectives and measures would apply to MIPS eligible clinicians, Qualifying APM Participants (QPs), and Partial QPs participating in an ACO.

Specifically, QPs, Partial QPs and all MIPS eligible clinicians participating in the ACO, regardless of track, must satisfy all of the following:

- Report the MIPS PI performance category measures and requirements to MIPS as either of the following:
    - All MIPS eligible clinicians, QPs, and partial QPs participating in the ACO as an individual, group, or virtual group; or
    - The ACO as an APM Entity.
- Earn a MIPS performance category score for the MIPS PI performance category at the individual, group, virtual group, or APM entity level.

A MIPS eligible clinician, QP, Partial QP or ACO as an APM Entity may be excluded from the requirement if they:

- Do not exceed the low volume threshold set forth in MIPS
- Are an eligible clinician who has opted to voluntarily report measures and activities for MIPS; or
- Have not earned a performance category score for the MIPS PI performance category because the PI category has been reweighted in accordance with MIPS PI reweighting policies at §414.1380(c)(2).

While CMS would allow reporting at individual, group, or virtual group options in addition to reporting as an APM Entity, the agency encourages ACOs to report MIPS PI at the APM Entity level for purposes of satisfying the MSSP requirement as proposed (see §425.507).

- If an ACO does not report at the APM Entity level, the ACO's individual and group scores would be calculated as a weighted average rolled up to the APM Entity level.
- If an eligible clinician reports PI at the individual or group level under traditional MIPS or the APP in addition to the ACO reporting MIPS PI at the APM Entity level via the APP, that eligible clinician would receive the highest of the individual, group or APM entity PI scores.

CMS notes that exclusions to MIPS eligible clinicians at §414.1310(b)(1)(i) and (ii) (FQHCs and RHCs) are not applicable to this proposal because QPs and Partial QPs are required to report MIPS PI for purposes of satisfying the MSSP requirements at §425.507. Examples of applicable exclusions under §414.1380(c)(2) for reweighting of the MIPS PI performance category include, but are not limited to MIPS eligible clinicians, QPs, and Partial QPs participating in the ACO who:

- Are granted a hardship exception under §414.1380(c)(2)(i)(C) at the individual, group, virtual group, or APM entity level,
- Are eligible for reweighting of the PI performance category at the individual, group, virtual group, or APM Entity level as described at § 414.1380(c)(2)(i)(A)(4)
- Are eligible for reweighting of the PI performance category as described at §414.1380(c)(2)(i)(A)(4).

Finally, CMS proposes to require ACOs to publicly report the number of MIPS eligible clinicians, QPs and Partial QPs participating in the ACO that earn a MIPS PI performance category score.

Beneficiary Assignment

CMS proposes to make changes to the claims-based assignment methodology, to the definition and calculation of the assignable beneficiary population, and to the definition of primary care services used in assignment.

Modifications to the Step-wise Assignment Methodology and Approach to Identifying the Assignable Beneficiary Population

According to statute beneficiaries must be assigned to an ACO based on their use of primary care services furnished by physicians participating in the ACO. Various MSSP operations are based on an ACO's assigned population, including eligibility and participation options and financial calculations. Additionally, the assignable beneficiary population is used in various calculations under MSSP, including national and regional benchmarking factors. Under current policy, CMS uses the following approaches and definitions:

- Physician pre-step. CMS uses a "pre-step" to the two-step claims-based assignment process in which the agency identifies all beneficiaries who had at least one primary care service furnished by a physician in the ACO, who is a primary care physician as defined under § 425.20 or has one of the primary specialty designations specified in § 425.402(c) during the applicable assignment window.
- Assignable beneficiary. CMS currently defines an assignable beneficiary as a Medicare Fee-for-Service (FFS) beneficiary who receives at least one primary care service with a date of service during a specified 12-month assignment window from a Medicare-enrolled physician who is a primary care physician or who has one of the specialty designations included in § 425.402(c).

CMS notes that the current approaches exclude from assignment beneficiaries who only receive primary care services from non-physician practitioners (NPs, PAs, and CNSs). CMS sees revising the pre-step and the definition of assignable beneficiary as an opportunity to expand the assigned and assignable populations. This would help achieve the goal of having all beneficiaries in an accountable care relationship by 2030. Analysis by CMS shows that proposed changes would reduce barriers for underserved beneficiaries to be assigned to ACOs. The following proposed changes would be effective for all MSSP ACOs beginning January 1, 2025.

Incorporating Use of an Expanded Window for Assignment

CMS proposes to use an expanded window for assignment in a new step three of the claims-based assignment process to identify additional beneficiaries that do not meet the physician pre-step. The expanded window for assignment is proposed to mean, "the 24-month period used to assign beneficiaries to an ACO, or to identify assignable beneficiaries, or both that includes the applicable 12-month assignment window and the preceding 12 months." For clarity, CMS also proposes to modify the definition of "assignment window," to mean, "the 12-month period used to assign beneficiaries to an ACO, or to identify assignable beneficiaries, or both." With these proposals, CMS seeks to better account

for beneficiaries who may be receiving their primary care predominantly from non-physician providers (NPPs) during the 12-month assignment window, but who received primary care from a physician in the preceding 12 months, in recognition of the statutory requirement.

Adding a Step Three to the Beneficiary Assignment Methodology
CMS proposes to add a third step to the claim-based assignment process, which would apply only to beneficiaries who do not meet the physician pre-step and who:

- Received at least one primary care service with a non-physician ACO professional in the ACO during the applicable 12-month assignment window, and
- Received at least one primary care service with a physician who is an ACO professional in the ACO and who is a primary care physician as defined under § 425.20 or has one of the primary specialty designations specified in § 425.402(c) during the applicable 24-month expanded window for assignment.

A beneficiary meeting these criteria would then be assigned to the ACO if allowed charges for primary care services furnished to the beneficiary by ACO professionals during the applicable expanded window for assignment are greater than the allowed charges for primary care services furnished to the beneficiary by providers who are ACO professionals in any other ACO or not affiliated with any ACO during the expanded window for assignment.

Beneficiaries would continue to need to meet the eligibility criteria under § 425.401(a) for the applicable 12-month assignment window and beneficiaries who meet the physician pre-step and are not assigned to an ACO in steps one or two would continue to not be assigned to an ACO under these policies. These policies would not affect voluntary alignment, which will continue to take precedence over claims-based assignment.

CMS proposes to continue to apply the current approach in which a beneficiary prospectively assigned to an ACO is not eligible for assignment to a different ACO for the same benchmark or performance year. Therefore, a beneficiary who is prospectively assigned through step one or two or proposed step three would remain assigned to that ACO for the benchmark or performance year, even if another ACO provides the plurality of the beneficiary's primary care services during the relevant benchmark or performance year. CMS expects there may be a small share of beneficiaries who would be prospectively assigned to an ACO under the proposed step three that differs from the retrospective ACO the beneficiary is currently assigned to under steps one or two.

CMS notes several potential effects of a larger assigned population as a result of these changes:

- More ACOs meeting the minimum size requirements to participate in MSSP
- Lower minimum savings rate (MSR) for ACOs subject a variable MSR
- Higher performance payment limits, which are based on a percentage of total expenditures
- Decrease in revenue-to-expenditure ratios, which could result in some ACOs being identified as low revenue instead of high revenue

Revising the Definition of an Assignable Beneficiary

CMS proposes to modify the definition of "assignable beneficiary" to be consistent with the use of an expanded window for assignment to identify additional beneficiaries to include in the assignable population after application of the existing methodology. Under this proposal, CMS would continue to use the existing definition of assignable beneficiary. A Medicare FFS beneficiary who does not meet this requirement but who meets both of the following criteria would also be considered an assignable beneficiary if the beneficiary:

- Received at least one primary care service with a date of service during a specified 24-month expanded window for assignment from a Medicare-enrolled physician who is a primary care physician or has one of the primary specialty designations specified in § 425.402(c) and
- Received at least one primary care service with a date of service during a specified 12-month assignment window from a Medicare-enrolled practitioner who is a nurse practitioner (as defined at § 410.75(b)), physician assistant (as defined at § 410.74(a)(2)), or a clinical nurse specialist (as defined at § 410.76(b)).

CMS also proposes that beginning January 1, 2025 (regardless of agreement start date), it would identify the national assignable population using the 24-month expanded window for assignment comprised of the 12-month calendar year assignment window (which aligns with the assignment window for preliminary prospective assignment with retrospective reconciliation) and the preceding 12 months. For identifying the assignable population for regional factors for PY 2025 and subsequent performance years, CMS proposes differential policies for ACOs continuing in agreement periods that began before PY 2024 and those beginning agreement periods in PY 2024 and subsequent performance years:

- **Before PY 2024:** CMS would use the 24-month expanded window for assignment comprised of the 12-month calendar year assignment window and the preceding 12 months.
- **PY 2024 and later:** CMS would use the 24-month expanded window for assignment that aligns with the assignment methodology selected by the ACO for the performance year.

CMS proposes to adjust benchmarks for all ACOs in agreement periods for which PY 2025 is a second or subsequent performance year at the start of PY 2025 so that the ACO benchmarks reflect use of the same assignment rules and definition of assignable beneficiary as would apply in the performance year.

Using CY 2021 data, CMS found that applying the proposed policies would grow the national assignable population by about 2.9 percent. Relative to the current assignable population, the group of added beneficiaries in the simulation had a larger share of beneficiaries with disabled Medicare enrollment type, resided in areas with higher Area Deprivation Index (ADI) national percentile rankings, and had a larger share with any months of Medicare Part D low-income subsidy (LIS) enrollment (see Table 30 for details).

Definition of Primary Care Services used in Shared Savings Program Beneficiary Assignment

CMS proposes to revise the definition of primary care services it uses to assign beneficiaries to ACOs, effective January 1, 2024, with the addition of the following codes:

(1) 99406, 99407 (smoking and tobacco-use cessation counseling services): similar to other preventive services which CMS currently includes (e.g., alcohol misuse screening and counseling)

(2) 99457, 99458 (remote physiologic monitoring (RPM) treatment management services): designated as care management services, which CMS broadly includes
(3) G0101 (cervical or vaginal cancer screening): preventive health service that can be provided in a primary care setting
(4) G2086, G2087, G2088 (office-based opioid use disorder services): requirements are similar to chronic care management, behavioral health integration, and collaborative care model codes, which CMS currently includes. CMS notes that these codes are excluded from MSSP Claim and Claim Line Feeds (CCLF) and therefore ACOs will not be able to see claims that may have been used in assignment and may not be able to identify why certain beneficiaries were assigned to their ACO related to these codes.
(5) G2211 (complex E/M services add-on)*: used in conjunction with office and outpatient E/M services which CMS currently includes
(6) GXXX1, GXXX2 (community health integration services)*: designated as care management services, which CMS broadly includes
(7) GXXX3, GXXX4 (principal illness navigation)*: designated as care management services, which CMS broadly includes
(8) GXXX5 (SDOH risk assessment)*: provided in conjunction with professional services and separately payable when provided with an AWV, which CMS currently includes 96202, 96203 (caregiver behavioral management training)*: CMS believes these services support the MSSP mission to provide coordinated, high quality care to ACO beneficiaries

**If finalized under Medicare FFS payment policies*

Benchmarking Methodology

CMS finalized several updates to the financial methodology in last year's MPFS for agreements beginning January 1, 2024. A summary of the changes can be found here and includes:

- Adding a prospectively projected administrative growth to update an ACO's historical benchmark;
- Accounting for an ACO's prior savings in rebased benchmarks;
- Reducing the cap on negative regional adjustments from -5 percent to -1.5 percent; and
- Incorporating demographic risk scores before applying ACOs' 3 percent cap on hierarchical condition code (HCC) risk score growth.

NAACOS submitted detailed comments in response to CMS's proposals that were generally supportive because they changes would create fairer, more accurate benchmarks for ACOs. We also noted several places where the policies could be improved to help ACOs, such as:

- Keeping the current two-way trend adjustment to benchmarks but use the new Accountable Care Prospective Trend (ACPT) as the national component of the update;
- Accounting for prior savings when an ACO is rebased but consider using an ACO's actual maximum shared savings rate and modify the 5 percent national spending cap in certain circumstances;
- Reducing the cap on negative regional adjustments; and
- Allowing current ACOs to opt into certain financial changes beginning in 2024.

In this year's proposed rule, CMS makes modifications to several of the policies it finalized last year.

Capping Reginal Risk Score Growth

CMS proposes to cap an ACO region's growth in risk scores similarly to how it caps the ACO's own risk score growth. This means that ACOs' region's risk score growth will be subject to a 3 percent cap, just like ACOs themselves have been since 2019. CMS proposes to apply the cap on the region independently, meaning the region could be subject to a cap in its risk scores, even if the ACO isn't. ACOs in regions with risk score growth below the cap would not be affected. CMS proposes to scale the cap to the ACO's market share within a region. Therefore, ACOs with a larger market share would see smaller increases compared to ACOs with a smaller market share if their region's risk scores increase above the 3 percent cap. The cap for both the ACO and region is applied separately for each enrollment type. If finalized, the change would apply to new agreements starting in 2024.

Under current policy, if ACOs operate in regions with risk scores that rise above 3 percent, then CMS effectively punishes the ACO twice – once with the cap and again by the regional adjustment, which is risk adjusted. According to CMS's analysis outlined in the proposed rule, 11 percent of ACOs in 2021 would have benefited from this proposed change. This number will increase as ACOs get further along in their 5-year agreement periods and would be more likely to hit the 3 percent cap.

NAACOS has advocated for this exact policy. CMS believes this change will incentivize ACO participation in regions with high risk scores and encourage ACOs to care for higher risk beneficiaries.

Eliminating the Negative Regional Adjustment

MSSP benchmarks are lowered for ACOs whose spending is higher than that of its region. This was done to not give high-spending providers an unfair advantage in earning shared savings, but harms ACOs whose patients are costlier. In this rule, CMS proposes to prevent any ACO from receiving a regional adjustment that would cause its benchmark to be lower than it would have been without the regional adjustment, effectively eliminating the negative regional adjustment. ACOs eligible for a prior savings adjustment would not have those savings offset by a negative regional adjustment. If finalized, this change would take effect for new agreements starting in 2024. There's no proposed change for ACOs with a positive regional adjustment.

No ACO is worse off under the proposed policy. CMS states ACOs who benefit from this change include those that serve high-cost, medically complex patients or ACOs who are higher spending than other providers in their region. An overwhelming majority of ACOs in the program, 82 percent, receive a positive regional adjustment, and those who receive a negative adjustment are twice as likely to drop out of MSSP. CMS estimated in the proposed rule that the average overall benchmark would increase be between 0.2 and 0.4 percent, a number that could be larger in the future as more ACOs become eligible for higher percentages of regional adjustments.

Proposal to Modify the Prior Savings Adjustment

In the final 2023 MPFS, CMS implemented a policy that adds some shared savings an ACO receives back into its benchmark. This reduces the so-called ratchet effect, which causes ACO benchmarks to be lower over time as they generate more and more shared savings. This year, CMS proposes to recalculate an ACO's prior savings adjustment if shared saving amounts are retroactively adjusted to account for either;

1) Compliance actions to address an avoidance of at-risk beneficiaries; or
2) A redetermination of shared savings or losses.

In either case, an ACO's shared savings generated in the three years immediately prior to the start of a new agreement may change. In these circumstances, CMS would adjust the historic benchmark for those ACOs.

If finalized, the change would take effect for agreements starting in 2024. The proposed change would only apply to ACOs who earned shared savings and received a prior savings adjustment in their benchmark. CMS would reserve the right to make changes at any point during any performance year of an ACO's agreement as well as after an agreement period ends. CMS may delay the initial release of ACOs' shared savings or losses to determine if an ACO should receive an adjusted benchmark. ACOs who already received their historical benchmark for their first year could still have their benchmark adjusted to account for these two scenarios.

Introduction of New Risk Adjustment Model Version

CMS will introduce a new risk adjustment model in Medicare Advantage beginning in 2024. This new model version, V28, collapses numerous codes and revalues remaining ones in a way that reduces patients' risk scores. Before this proposed rule, it was unclear how CMS would implement this new model version for Medicare ACO programs.

For agreements beginning in 2024, CMS proposes to use the same HCC risk adjustment model for a performance year and the relevant benchmark years. This means that as CMS introduces new risk adjustment models, including the forthcoming V28 model, that risk scores would be calculated using a consistent model and any impacts a shift in the model version could create should be balanced.

Importantly, these changes will only apply for agreement periods beginning in 2024 with CMS saying it historically incorporates changes to the benchmarking methodology at the start of an ACO's agreement period. ACOs not starting new agreements in 2024 will have different risk models for benchmark and performance years.

CMS analyzed the switch to the new V28 model in the proposed rule. It found that shared savings payments would have been 11 percent lower in 2021 had V28 been used in the performance year and V24 been used for the benchmark year. This compares to shared savings payments being 2 percent higher that year if V28 were used in both the performance and benchmark years. NAACOS performed its

own analysis of the switch and found a similar conclusion: that dual eligible and disabled beneficiaries would be disproportionately harmed by the move to V28.

CMS's proposed approach would reduce the negative impact for ACOs with high risk scores, earlier entry dates, and those who participate in a two-sided risk model. Because MSSP benchmarks are influenced by ratios of risk scores (specifically, the ratio of patients' scores between a benchmark year and corresponding performance year), using the same model version in both years mitigates any negative impact from a shift in the risk model. ACOs not starting new agreements next year and still subject to "model skew" may be helped by renormalization, risk-adjusted regional spending, and a blended introduction of V28, as discussed later in this analysis.

Blending of New Risk Model Versions

CMS proposes to phase in the new V28 model over a three-year period, similar to how it will do for Medicare Advantage plans starting next year. This will apply to all MSSP ACOs, not just those starting new agreement periods. This means risk scores in 2024 will be comprised of one-third of the new V28 model and two-thirds of the current V24 model. In 2025, it will be two-thirds V28 and one-third V24. By 2026, it will be entirely comprised of V28. The table describes the transition.

	V24	**V28**
2024	67%	33%
2025	33%	67%
2026	0%	100%

Blending the two model versions will help reduce any potential negative impact on ACOs, particularly those serving higher risk patients. Lastly, CMS will also codify its risk adjustment approach, which currently is missing from the regulations that govern the MSSP.

While introducing V28 in a blended fashion will reduce the impact for everyone, only new ACOs will have a similar risk model applied to their benchmark and performance years, as stated above. ACOs operating under agreement periods that started before 2024 may have benchmark years based partially or entirely on old risk models, including the current V24 model or the 2014 CMS-HCC model, Version 22.

Advance Investment Payments

CMS previously finalized the Advance Investment Payment (AIP) to begin with ACOs entering agreement periods on January 1, 2024. CMS proposes to refine AIP policies to better prepare for initial implementation of AIP.

Modifying AIP Eligibility Requirements to Allow ACOs to Advance to Performance-Based Rick During the 5-Year Agreement Period

Current policies require an ACO to remain under a one-sided model for the duration of the agreement period in which it receives AIPs to remain compliant with AIP requirements. Regulations finalized in the

2023 MPFS rule state that "CMS will terminate an ACO's AIPs in accordance with § 425.316(e) if the ACO is no longer inexperienced with performance-based risk Medicare ACO initiatives or is no longer a low revenue ACO," and that if the ACO remains experienced or high revenue after a deadline specified by CMS, "the ACO must repay all AIPs it received." Because of these policies, it is only ACOs that enter the Basic Track at Level A, not "any level of the Basic Track's glide path" that are truly eligible for AIP, because those that enter at or move into Levels C–E during the agreement period would not be eligible to continue receiving AIPs and would be considered non-compliant and be required to immediately repay all AIPs received.

CMS proposes to modify these policies to allow an eligible ACO receiving AIPs to advance to performance-based risk (i.e., Level C, D, or E) beginning in PY3 of the ACO's agreement period. As part of this change, CMS would also modify the monitoring policies to specify that CMS would cease payment of AIPs if CMS determined that an ACO approved for AIP becomes experienced during the first or second performance year of its agreement period or became a high revenue ACO during any performance year of the agreement period in which it received AIPs.

Under this proposal, an ACO in an agreement period in which it receives AIPs may participate as follows:

PY1	Level A
PY2	Level A (in accordance with § 425.600(a)(4)(i)(C)(3)) or Level B
PY3 – 5	Level A (in accordance with § 425.600(a)(4)(i)(C)(3)) or Levels B – E

If an ACO opts to progress to a two-sided risk model prior to PY3, CMS would terminate the ACO's receipt of AIPs, the ACO would be subject to compliance action, and CMS may seek immediate repayment of AIPs.

Modifying AIP Recoupment and Recovery Policies for Early Renewing ACOs

Under current policies, if an ACO terminates its participation agreement during the agreement period in which it received AIP, the ACO must repay all AIPs received within 90 days of notification by CMS. CMS notes it did not address potential interactions between AIP recovery policies and voluntary termination of the participation agreement by an ACO that is seeking to early renew.

CMS proposes to amend AIP recovery policies under § 425.630(g)(4) to create a limited exception for an ACO that voluntarily terminates at the end of PY2 or later during the agreement period in which it receives AIPs provided the ACO immediately enters into a new participation agreement under any level of the Basic Track or the Enhanced Track. For such ACOs, CMS would carry forward any balance of AIPs owed into the ACO's new agreement period and recoup the AIPs through future shared savings earned by the ACO. If an ACO early renews prior to PY3, it will no longer comply with AIP eligibility requirements and may be subject to compliance action.

Under this section, CMS also proposes to permit an early renewing ACO to spend AIPs in its second agreement period so long as the AIPs are spent within five performance years of when it began to receive AIPs. Any unspent AIPs at the end of the fifth performance year must be immediately repaid to CMS.

CMS notes that some policy changes are applicable only to new agreement periods, and ACOs approved for AIP should have the opportunity to enter into a new agreement to experience such changes.

Amending Termination Policies to Allow CMS to Cease Distribution of Advance Investment Payments Following an ACO's Notification of Voluntary Termination

Current AIP policies state that ACOs that terminate participation (whether initiated by CMS or the ACO) during the agreement period in which AIPs are received will be obligated to repay all AIPs received within 90 days of notification of the amount due by CMS. Therefore, it does not make sense for CMS to continue distributing AIPs to an ACO that has notified the agency of its intent to voluntarily terminate given the funds will need to be immediately repaid following termination.

CMS proposes to cease paying AIPs to an ACO that has provided the agency with notice of termination if the ACO will not immediately enter a new agreement period (early renew), and the ACO would be obligated to repay all AIPs in accordance with § 425.630(g)(4).

Requiring ACOs to Report to CMS Spend Plan Updates and use of AIPs

Current policies require ACOs to publicly report the ACO's spend plan, the total amount of AIPs received, and an itemization of how AIPs were spent during the performance year. CMS proposes to require ACOs to report to CMS, in a form and manner and by a deadline specified by CMS, the same information that they are required to publicly report. CMS expects to use the submitted data as the template that ACOs can use to populate their public reporting webpage early in each performance year to minimize administrative burden for ACOs.

Permitting Reconsideration Review of Quarterly Payment Calculations

Current policies allow ACOs to request a reconsideration review if CMS does not make an AIP to the ACO in a given quarter. CMS proposes to permit an ACO to request a reconsideration review for all AIP quarterly payment calculations, not just instances where no payment is distributed. ACOs would be informed of this right when CMS provides written notice of the quarterly payment amount calculated by CMS.

Eligibility Requirements

CMS proposes two modifications to MSSP eligibility requirements that, if finalized, would be effective January 1, 2024.

Shared Governance Requirements

CMS proposes to remove the option for ACOs to request an exception to the requirement that 75 percent control of the ACO's governing body must be held by ACO participants. CMS notes that to date, no ACO has been granted an exception to the requirement and CMS has not denied participation to any

ACO based on failure to comply with the requirement. Given this, CMS feels there is no reason to continue to offer the exception.

Identifying ACOs Experienced with Risk Based on TINs' Prior Participation

Current regulations do not specify how CMS determines whether an ACO participant TIN has "participated" in a performance-based risk Medicare ACO initiative ("Initiative ACO"). CMS proposes to codify the current operational approach for determining whether an ACO participant has participated in an Initiative ACO based on whether its TIN was or will be used to calculate financial reconciliation for the entity participating in the Initiative ACO. If the ACO participant was included on an Initiative ACO's participant list but the ACO voluntarily terminates before the deadline for reconciliation or is otherwise not eligible for reconciliation, the ACO participant will not be considered to have experience with risk because its claim experience would not be used to financial reconciliation.

CMS proposes to modify the existing definitions for "experienced" and "inexperienced" to include the language, "An ACO participant is considered to have participated in a performance-based risk Medicare ACO initiative if the ACO participant TIN was or will be included in financial reconciliation for a performance year under such initiative during any of the five most recent performance years."

Technical Changes

CMS has identified several inconsistencies and typographical errors in MSSP regulatory text that it proposes to correct and clarify:

- Revising five references to ACO assignment methodology selection for clarity and consistency.
- Correcting the inaccurate use of "rural health center" to the correct term, "rural health clinic" and clarifying that all uses of the acronym "RHC" or "RHCs" have been interpreted to refer to "rural health clinic(s)."
- Correcting a typographical error in the definition for "At-risk beneficiary" at § 425.20 by replacing the word "Medicaid" in paragraph (7) with the word "Medicare."
- Updating outdated terminology on data sharing with ACOs by replacing references to "Health Insurance Claim Number (HICN)," which was discontinued in 2019, with the term "beneficiary identifier," and revising the list of purposes for which an ACO may request certain beneficiary-identifiable data to replace the term "process development" with "protocol development."

Future Developments for Sharing Savings Program Policies

CMS discusses its desire to continually innovate and improve the MSSP. Accordingly, the agency is seeking comment on potential future options. These requests for information are not proposals but rather an opportunity to provide input on policies that may be proposed in the future. In addition to the items discussed below, CMS noted that it is considering a hybrid prospective primary care payment for MSSP.

Incorporating a Higher Risk Track than Enhanced

CMS sought feedback on, but did not propose, creating another track in the MSSP that offers higher levels of risk and reward than the current Enhanced Track. NAACOS has advocated for such an option, which we've called "Enhanced Plus." Such an option would encourage ACOs to take on higher levels of risk, which would in turn produce higher savings, drive innovation, and improve patient care overall. Enhanced offers 75 percent shared savings and 40 percent shared losses. But the only option for full risk is ACO REACH, which is currently closed to applications.

CMS noted concern about selection. Specifically, only ACOs who stand to financially benefit from an Enhanced Plus track would participate. Additionally, CMS is concerned that ACOs in a high-risk track would avoid high-cost patients. As such, the agency is seeking feedback on designing a model that would not increase Medicare spending and protect high-risk patients. CMS notes altering its approach to truncating expenditures and capping shared savings and shared losses as options for protecting ACOs that serve high-risk beneficiaries.

Increasing the Amount of the Prior Savings Adjustment

For contracts beginning in 2024, CMS previously finalized adding back half of ACOs' prior savings to its benchmark, which cannot exceed 5 percent of national FFS spending, the same cap applied to an ACO's positive regional adjustment. CMS is seeking comments on increasing that 50 percent scaling factor or other alternatives for measure savings generated in a way that don't overly inflate ACOs' benchmarks while still reducing the ratchet effect.

While other stakeholders, such as the Medicare Payment Advisory Commission, noted that both a prior savings adjustment and reduced negative regional adjustment would be duplicative and lead to excessive savings for ACOs, NAACOS noted that a cap on the prior savings adjustment harms both extremely efficient ACOs (because the adjustment is capped at 5 percent of national FFS spending) and ACOs with higher cost patients (because the dollar amounts on their patients are higher, making the adjustments effectively lower).

Expanding the ACPT Over Time and Addressing Overall Market-wide Ratchet Effects

Following NAACOS advocacy, CMS is seeking feedback on future refinements to its new Accountable Care Prospective Trend (ACPT). For agreements starting 2024 and beyond, MSSP benchmarks will be a combination of two-thirds of the current national-regional blend rate and one-third of the ACPT. NAACOS expressed concerned that the ACPT, because it's based on national Medicare spending, would hurt ACOs in regions whose spending growth was higher than the ACPT. According to our analysis, that's about a third of ACOs. Instead, we offered other alternatives, including replacing the national trend in the current two-way blended update with the ACPT. CMS now seeks comment on that approach, along with scaling the weight of the ACPT to account for ACOs' market share in its region.

Promoting ACO and CBO Collaboration

CMS is seeking feedback on general approaches for encouraging or incentivizing increased collaboration between ACOs and community-based organizations (CBOs). CMS notes CBOs refer to public or private not-for-profit entities that provide specific services to the community or targeted populations in the community to address the health and social needs of those populations. CMS also seeks comment on potential changes to MSSP's patient-centered care requirements to strengthen partnerships between ACOs and interested parties in the community, including CBOs, to address unmet health related social needs.

MIPS Value Pathways (MVP) Reporting for Specialists in Shared Savings Program ACOs

CMS solicits comments on scoring incentives that would be applied beginning in PY 2025 when specialists who participate in an ACO report quality MVPs. CMS is considering adding bonus points for ACOs with specialists reporting quality MVPs, up to 10 points added to an ACO's health equity adjusted quality performance score if they meet data completeness requirements. CMS notes its goal is to have specialists participate in ACOs in a meaningful way and to collect quality data that is comparable to data reported by other specialty providers in MVPs. CMS notes it only seeks to offer bonus points as a temporary policy to incentivize MVP reporting. Once specialists are reporting MVPs, CMS anticipates evaluating overall aggregate specialty performance within an ACO. CMS seeks comment on how the agency should consider assessing overall specialty performance as part of the APP in the future.

QUALITY PAYMENT PROGRAM

Merit Based Incentive Payment System

CMS proposes to set the MIPS threshold at 82 points (up from 75 points) for PY 2024. The maximum adjustment that can be received under MIPS is +/-9 percent for PY 2024. However, due to budget neutrality requirements and so few clinicians receiving penalties in the program, bonuses for this program have remained low (around 2 percent for a score of 100).

CMS also proposes changes to the calculation to establish annual MIPS thresholds to incorporate three years of performance data. CMS does not propose any changes to the performance category weights for ACOs subject to MIPS (Quality 50 percent, Cost 0 percent, Improvement Activities 20 percent, and Promoting Interoperability 30 percent). Table 52 provides an illustration of the point system and associated adjustments with a comparison between PY 2023 and 2024.

Promoting Interoperability

ACOs subject to MIPS must report the Promoting Interoperability performance category measures and objectives. CMS also proposes several minor updates to Promoting Interoperability measures and objectives. Notably, CMS proposes to increase the reporting period for Promoting Interoperability from 90 days to 180 continuous days in the calendar year. Promoting Interoperability proposed changes are

outlined in Table 45, Objectives and Measures for the Promoting Interoperability Performance Category for the 2024 Performance Period.

MIPS Targeted Review Process

CMS proposes changes to the targeted review timeline for MIPS. CMS proposes to allow submission of a request for a targeted review of MIPS scores beginning on the day final MIPS scores are made available and ending 30 days after publication of the MIPS payment adjustment factors for the MIPS payment year (approximately 60 days). CMS believes this will allow them more time to adjudicate targeted reviews and finalize QP status lists by October 1st. Additionally under this new approach if CMS requests additional information under the targeted review, it must be provided and received by CMS within 15 days of receipt of such request.

Advanced Alternative Payment Models

The Consolidated Appropriations Act (CAA), that was signed into law in December included a one-year extension of advanced APM incentives at a reduced 3.5 percent rate for PY 2023. The 3.5 percent incentive will be paid in 2025 and calculated based on a clinician's estimated aggregate payment amounts for Medicare Part B covered professional services in the preceding year. The CAA also included a provision to keep QP thresholds at current levels for PY 2023.

NAACOS worked closely with lawmakers last year to pass the one-year 3.5 percent advanced APM incentive extension and QP threshold freeze. While we are pleased that CMS is implementing both policies in this fee schedule, we remain concerned that the expiration of the incentive payment and threshold freeze at the end of the year will slow the transition to value. As a result, NAACOS is calling on lawmakers to support a two-year extension of the original 5 percent advanced APM incentive payment, along with giving CMS more flexibility to set QP thresholds.

QP Determinations and Thresholds

CMS is proposing to calculate future QP determinations at the individual level for each unique NPI. This change would take place in PY 2024 and represent a significant change from the current policy where calculations are done at the APM entity level. CMS is also proposing changes to attribution to help streamline QP determinations. The agency is proposing to update the definition of "attribution-eligible beneficiary" to include all covered professional services, not just E/M services.

In the CY 2023 MPFS, CMS issued a request for information on this proposed change. NAACOS encouraged the agency not to move forward with the proposal highlighting that the current determination process treats the ACO as whole. We also expressed concern that the changes could serve as a disincentive for some specialists to join ACOs and increase burdens on ACOs.

Additionally, QP thresholds will increase for PY 2024 unless changes are made by Congress. This will make it more difficult for some clinicians in ACOs to achieve QP status. The agency is also estimating a

reduction of between 30,000–84,000 QPs in 2024, which is likely a result of increasing thresholds, changes to the QP determination process, and expiring advanced APM incentives.

2024 QP Thresholds	
Medicare Payment Amount	**Medicare Patient Count**
QP thresholds increase from 50 percent to 75 percent Partial QP thresholds increase from 40 percent to 50 percent	QP thresholds increase from 35 percent to 50 percent Partial QP thresholds increase from 25 percent to 35 percent

NAACOS is working with lawmakers to advance legislation that extends advanced APM incentives and ensures qualifying thresholds remain attainable. This will help promote program growth by giving CMS the authority to adjust qualifying thresholds through rulemaking and set varying thresholds for more targeted models where participants (i.e., specialists) cannot meet the existing one-size-fits-all thresholds that have been established by Congress.

QP Conversion Factor Updates

Beginning with PY 2024, QPs will be eligible to qualify for higher Medicare payment updates beginning in payment year 2026. The Medicare Access and CHIP Reauthorization Act (MACRA) provided a 0.75 percent conversion factor update for QPs and 0.25 percent updates for non-QPs.

It's important to note that the current advanced APM incentive payments are not included in calculations for the purposes of rebasing ACO benchmarks nor are they counted as expenditures for the ACO. NAACOS is concerned that under current law when QPs receive a higher 0.75 percent conversion factor update beginning in payment year 2026, it will be more difficult for ACOs to reduce spending below benchmarks. This is because ACO benchmarks are based on national and regional spending trends. Since most providers are still participating in MIPS, benchmarks will be reflective of the lower 0.25 payment updates. NAACOS will be engaging with CMS and Congress to ensure that proper safeguards are established to ensure that payment updates for clinicians do not negatively impact their financial performance in their models.

Targeted Review of QP Determinations

In payment year 2026, CMS will begin implementing higher conversation factor updates for QPs. To prepare for this transition, CMS is proposing to adjust the Targeted Review period beginning with PY 2024 to adjudicate the agency's targeted reviews and finalize the QP status list annually by October 1st.