



Proposed 2023 Medicare Physician Fee Schedule Rule: *Big Changes in Store for ACOs*



**July 20, 2022
1:00 pm ET**

Agenda



Welcome and Introductions

Review of the proposed CY2023 Medicare Physician Fee Schedule rule

- MSSP proposals:
 - Glidepath to risk
 - Financial methodology
 - Assignment and burden reduction
 - Advance investment payments
 - Quality
- QPP proposals:
 - MIPS
 - Advanced APMs

Audience Q&A

Housekeeping.....



Webinar is being recorded

The recording and slides will be available on the NAACOS website within 24 hours
You will receive an email when they are available.



We will take questions at the end of the program

At any time, please submit written questions using the **Questions tab** (not chat) on the dashboard to the right of your screen

Speakers



	<p>Clif Gaus President and CEO NAACOS</p>		<p>Aisha Pittman Senior Vice President of Government Affairs NAACOS</p>
	<p>Jennifer Gasperini Director of Regulatory and Quality Affairs NAACOS</p>		<p>David Pittman Senior Policy Advisor NAACOS</p>
	<p>Alyssa Neumann Health Policy Analyst NAACOS</p>		<p>Robert Daley Senior Policy Advisor NAACOS</p>

Overview and Key Payment Changes



Proposed 2023 MPFS Rule



- CY 2023 MPFS Proposed [Rule](#) Released July 7, comments due September 6
 - Submit your comments via [regulations.gov](https://www.regulations.gov), reference CMS-1770-P
- Several wins in proposed rule
 - ✓ Additional time in upside only for new ACOs
 - ✓ Retaining upside-only for existing upside-only ACOs
 - ✓ Benchmark policies that address:
 - ✓ Risk adjustment caps
 - ✓ ACO historical spending and growth trends
 - ✓ Regional adjustments
 - ✓ Improved quality performance Standard
 - ✓ Up-front incentive payments for certain ACOs
 - ✓ Continued focus on increasing program participation

NAACOS Resources:

- [Press statement](#)
- In-depth analysis [coming soon](#)
- Financial methodology [webinar](#) on July 28
- Email us your feedback—advocacy@naacos.com
- [NAACOS Fall conference](#) Sept. 7-9 in Washington, DC

CMS Resources:

- CMS fact sheet
- CMS [fact sheet](#)
- QPP [factsheet](#)

Payment and E/M Updates



- Estimated 2023 Conversion Factor (CF) of 33.0775; 4.4% lower than the 2022 CF of 34.6062
 - Conversion Factor calculated as though one-time 3% payment increase in CY 2022 was not applied, per Consolidated Appropriations Act (CAA)
 - MACRA Statutory Update of 0%
 - RVU Budget Neutrality adjustment of -1.5%
- Rebase and revising the Medicare Economic Index (MEI) to reflect more current market conditions faced by physicians
 - See Table 30: Proposed 2017-based MEI and 2006-based MEI Cost Categories and Weights
- Update Evaluation and Management (E/M) to align with AMA's revised CPT E/M guidelines for Other E/M visits
 - Other E/M visits include inpatient and observation visits, emergency department visits, nursing facility visits, domiciliary/rest home visits, home visits, and cognitive impairment assessments
 - Based on medical decision making or time

Proposed Changes to the Pathways to Success Glidepath

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Proposed Glidepath Changes (summary)



Inexperienced with risk: 7 years upside only

Inexperienced with risk and low revenue: 12 years upside only

Current Track A/B participants can stay upside-only for the remainder of their agreement

Enhanced Track Optional

Proposed Glidepath Changes



- **CMS proposes changes to allow additional time in upside only models**
- **ACOs Inexperienced with Risk:** Starting Jan. 1, 2024, ACOs inexperienced with performance-based risk can participate in one 5-year agreement under a one-sided model (Basic Track Level A for all 5 years)
 - If they remain eligible, these ACOs are permitted another 5-year agreement period progressing through the Basic Track Levels A-E
 - If ineligible to continue in the Basic Track for a second agreement period, the ACO will participate in Basic Track Level E for all 5 years of the second agreement period (or go to Enhanced)
- **Additional option proposed:** Allow two, five-year agreements in Level A, plus another agreement period in the Basic Track (up to 12 years no risk) for low revenue ACOs with no experience with performance-based risk, entering as a new legal entity
- **Current ACOs in A/B:** Starting Jan. 1, 2023, ACOs currently participating in Basic Track Level A or B could elect to continue in their current level of the Basic Track for the remainder of the agreement
 - Starting 7/22/22 ACOs can make this election in the ACO-MS. Deadline to make the election is September 9th at noon/12 PM Eastern- see ACO Spotlight Issue #14

Proposed Glidepath Changes



- **Definition of risk:** CMS 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
- **CMS Monitoring:** CMS will monitor ACOs identified as inexperienced with performance-based risk and participating in the Basic track under a one-sided model for changes to their ACO participant list, using a 5-year rolling lookback period (for example, PY 2020 through PY 2024, if PY 2025 were under review)
 - If determined to meet the definition of having experience with performance-based risk, the ACO can stay in their current level for the remainder of the performance year and will be required to advance to Basic Level E at the start of the next performance period
 - CMS will re-assess proposed participant lists each year

Financial Methodology

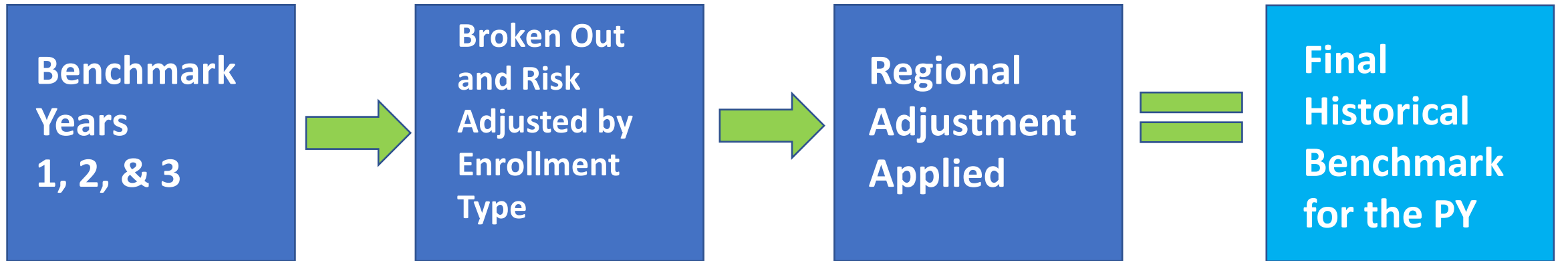


Agenda



- **Financial Methodology**
 - Adding a prospective growth factor into a new three-way trend
 - Risk adjustment change
 - Accounting for prior savings
 - Negative regional adjustment
 - Shared savings for low revenue ACOs below the MSR
 - Regional adjustment under prospective assignment
 - COVID-19 effects
- **All of CMS's proposed benchmarking changes would take effect for new agreements starting in 2024**

Background on Benchmarking



For ACOs starting new agreements in 2023, these years would be 2020-2022

There are a number considerations made to account for spending by different enrollment types – aged, disabled, dual eligible, and ESRD

CMS uses a blend of national and regional spending that depends on the ACO’s size in its market and spending relative to its region

The sums of these changes give an ACO’s updated historical benchmark

More detail can be found in [this CMS guidance](#)

Prospective Growth Updates in BM'ing



- CMS proposes a prospective administrative growth factor, which it calls the “Accountable Care Prospective Trend” (ACPT)
- This would create a three-way blend, along with national and regional growth rates, to update a benchmark for each performance year in an ACO’s agreement period
 - Based on 5-year-projections in per capita spending at the start of an ACO’s agreement period
 - Projected by the CMS Actuary and would be a modification of the existing FFS U.S. Per Capita Cost growth trend projections used annually for establishing Medicare Advantage rates
 - Could be two or more numbers if one number isn’t accurate enough
 - Risk adjusted and truncated at the 99th percentile
 - Flat dollar amounts calculated separate for each of the four enrollment types
 - Not adjusted for geographic differences in costs or prices
 - Would take effect for ACOs starting new agreements in 2024, if finalized
- CMS retains discretion to decrease the weight of the ACPT in the three-way blend¹⁵

Prospective Growth Updates in BM'ing



Two-way blend (Assumes a 3% national assignable growth, 2.5% regional growth and an ACO that's 20% of its region)

- $(\text{National Update Factor} \times \text{National Weight}) + (\text{Regional Update Factor} \times (1 - \text{National Weight}))$; or
- $(1.030 \times 20 \text{ percent}) + (1.025 \times 80 \text{ percent}) = \mathbf{1.026}$
- Using this method, an ACO's updated benchmark is **\$12,312** ($\$12,000 \times 1.026$)

Three-way blend (Assumes a 5% per year growth rate)

- $[\text{PY1 ACPT} \times (1/3)] + [\text{PY1 Two-Way Blend} \times (2/3)]$; or
- $\text{Three-way blend} = [1.056 \times (1/3)] + [1.026 \times (2/3)] = \mathbf{1.036}$
- Using this method, an ACO's updated benchmark is **\$12,432** ($\$12,000 \times 1.036$)
- That's **\$120/per patient** higher than the current method

Prospective Growth Updates in BM'ing



Could be better over current policy because:

- Would reduce the degree to which ACOs' savings negatively impact its benchmark
- Would provide more certainty for ACOs because the prospective trend would be set at the start of the agreement period
- CMS projects an average of 62% of all ACOs would have received a larger benchmark when it analyzed 2014-2019 data, an average of \$19 per capita
 - If an ACO has losses because under three-way blend, CMS says it'll calculate an updated BM using the current two-way blend and take the smaller amount of shared losses

Potential areas of concern:

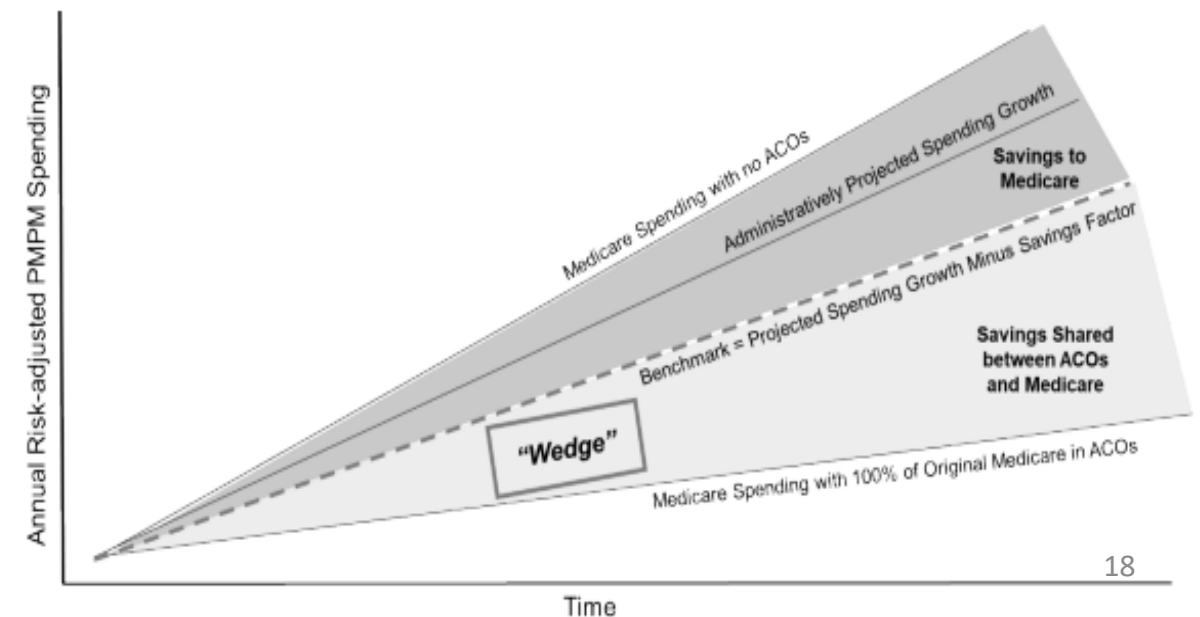
- This doesn't fix the "rural glitch" – just lessens its impact
- If 62% of ACOs had higher benchmarks, 38% would have had lower benchmarks
- There are year-over-year changes in spending, especially from region to region

Prospective Growth Updates in BM'ing



- CMS calls these proposed changes “stepping stones” to a potential longer-term approach, including potentially administratively set benchmarks
- Administratively set benchmarks have been recommended by MedPAC and health policy thought leaders, some of whom work as consultants to CMS
- “Ratcheting effect” becomes a serious consequence as ACOs continue to reduce spending and CMS strives toward its goal of 100% ACO penetration in Medicare
- There is concern the regional adjustment has led to adverse self selection among ACOs

FIGURE 3: Illustrative Example of Administratively-Established Benchmarking Approach



Risk Adjustment Changes



- Proposes to account for changes in ACOs' demographic risk scores before applying its 3% cap on HCC risk scores and apply the cap in aggregate across all four enrollment types
 - Demographic risk scores are based on patient demographics (age, sex, Medicaid status, etc)
 - Unlike HCC risk scores, demographic risk scores aren't subject to coding intensity
- A similar policy was added to ACO REACH starting in 2024
- Ex. Demographic risk score=1.026 and HCC cap of 0.03. Then new cap is 1.056
 - CMS simulations shows 45% of ACOs have higher BMs, 5% have lower BMs, 50% unaffected
- CMS acknowledged concerns expressed by NAACOS and others around the 3% cap on risk scores
 - NAACOS submitted comments in response to an RFI in last year's PFS
 - CMS notes the negative implications current policy has on addressing health equity

Other Benchmarking Changes



Adjusting ACO Benchmarks to Account for Prior Savings

- CMS proposes to reinstitute a policy where an ACO's savings generated in the previous agreement period are accounted for when rebasing new benchmarks
- This was first implemented in 2015 rulemaking and removed the next year when regional adjustments were incorporated
 - CMS felt benchmarks would “become overly inflated for some ACOs” benefiting from the regional adjustment
- CMS proposes to use the average per capita savings or losses generated by ACOs during the 3 baseline years that constitute its next its agreement period
 - This includes all savings generated, not just savings that exceed the MSR
- CMS proposes different scenarios to account for ACOs whose spending is both above and below its region

Other Benchmarking Changes



Reducing the Impact of the Negative Regional Adjustment

- ACOs' regional adjustment is capped at +/-5% of national per capita spending for each enrollment type
 - For ACOs with spending below their region, the regional adjustment is **35%** in the first agreement and **50%** in the 2nd and subsequent agreements
 - For ACOs with spending above their region, the regional adjustment is **15%** in the first agreement and **25%, 35%, and 50%** in in the 2nd, 3rd, and 4th agreements
- CMS wants to reward ACOs with low spending and entice ACOs with high spending to enter and remain in MSSP
- In the proposed rule, CMS said it now believes the current -5% cap may not limit the negative regional adjustment for ACOs serving high cost, complex patients
- Proposes to reduce the cap on negative regional adjustments to -1.5%
- Further adjusted to account for dual eligible and weighted HCC risk scores

Other Benchmarking Changes



Increased Opportunities for Low Revenue ACOs to Share in Savings

- CMS proposes to allow low revenue ACOs in the Basic Track to earn some shared savings even if they fail to meet or exceed their MSR
 - Maximum savings rate of **20%** instead of 40% under Levels A and B
 - Maximum savings rate of **25%** instead of 50% under Levels C, D, and E
 - Must have 5,000 assigned beneficiaries at the time of financial reconciliation
 - Available to all low revenue ACOs in Basic, including new, renewing, and re-entering ACOs
- ACOs must still meet the quality performance standard
 - For ACOs that do not meet the quality performance standard but meet the proposed alternative quality performance standard, the sharing rate would be further adjusted on a sliding scale
 - Would reflect the inclusion of health equity adjustment bonus points

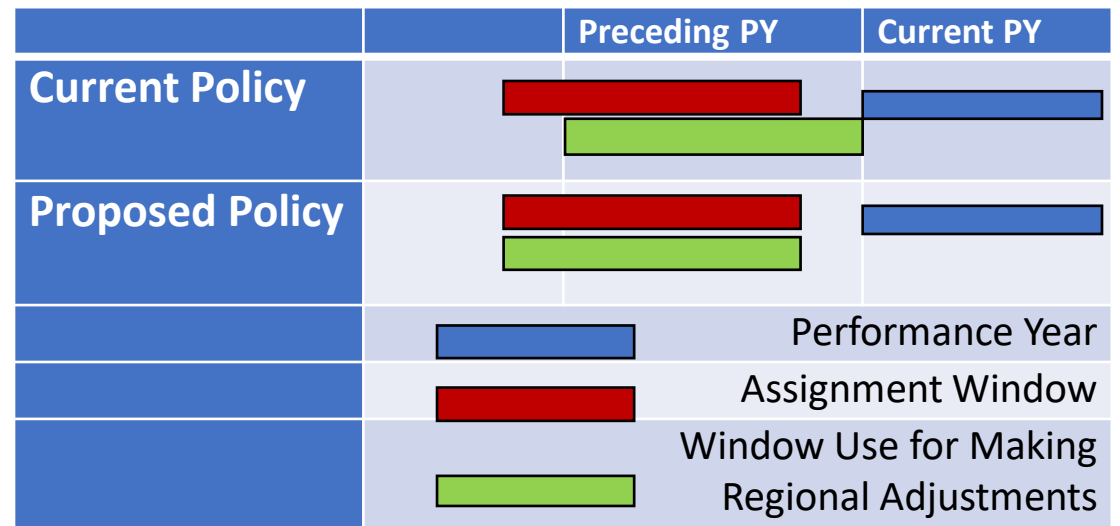
Other Benchmarking Changes



Calculating the Regional Adjustment for ACOs using Prospective Assignment

- CMS still uses the previous calendar year to base certain financial calculations for all ACOs, regardless of their using prospective or retrospective assignment
- CMS proposes to calculate regional spending using an off-set assignment window that matches that of ACOs under prospective assignment
 - Not proposing changes to national factors in financial calculations

- CMS estimates that benchmarks were 0.2% to 1.9% higher for ACOs under prospective assignment than they would have been if the regional adjustment been based on an offset assignment window



- The median estimated bias was 1.0%
- This bias grew under Pathways as more ACOs began receiving regional adjustments

COVID-19 Effects



- CMS acknowledged concerns raised by NAACOS and others about the impact of COVID-19 and resulting disruptions in care and utilization patterns would have on future ACO benchmarks
 - We led [a letter](#) to CMS last October asking that ACOs be allowed to select pre-pandemic years as a baseline for benchmarks
- The CMS Actuary indicates that spending rebounded in 2021 and that averaging 2020 and 2021 represents a “reasonable basis” on which to base benchmarks
- The current national-regional trend and various other update factors “will be sufficient to address and mitigate” the PHE’s impact
- CMS didn’t propose additional changes but promises to continue to monitor COVID-19’s impact on ACOs

Assignment and Burden Reduction



Beneficiary Assignment



- Revise the definition of primary care services used for MSSP assignments to include prolonged services (HCPCS codes GXXX2 and GXXX3) and chronic pain management (HCPCS codes GYYY1 and GYYY2)
- Update the description of E/M Home Services (CPT codes 99341 through 99350) to remove the reference to “service modifier 12”; this will expand the definition to include services provided in assisted living facilities, group homes, custodial care facilities, and residential substance use treatment facilities
- New policies for using CMS Certification Numbers (CCNs) in assignment
 - Capture newly-enrolled CCNs for all FQHCs, RHCs, CAHs and ETA hospitals under an ACO participant TIN at the start and periodically during the PY
 - Only applies for ACOs that have selected preliminary prospective assignment with retrospective reconciliation
 - CMS will develop a mechanism for reporting to ACOs all CCNs used in assignment and for purposes of program operations

Administrative Burden Reduction



- Remove the requirement that ACOs must submit marketing materials to CMS before use; must be provided upon request by CMS
- Modify the beneficiary notification requirements so that ACOs must furnish the beneficiary notice **once per 5-year agreement period**, rather than annually
 - CMS also proposes to establish a **new follow-up communication** that must be provided within 180 days of providing the notice or at the next primary care visit; follow-up may be verbal or written and must include a meaningful opportunity for beneficiaries to ask questions and engage; ACOs are given flexibility in how to furnish the follow-up but must document how this communication is implemented
 - CMS also clarifies that ACO participants must post signs in ALL facilities (whether or not primary care services are provided)
- Streamline the SNF 3-Day waiver review process by removing the requirement for ACOs to submit plan narratives; must be provided upon request by CMS
- Modify the MSSP data sharing regulations to specify that ACOs acting as organized health care arrangements (OHCA) may request aggregate reports and beneficiary identifiable claims data from CMS

Advance Investment Payments



Advance Investment Payments



- CMS proposes to make advance shared savings payments, referred to as advance investment payments (AIPs) available to certain ACOs participating in MSSP beginning Jan. 1, 2024
 - Modeled after the [ACO Investment Model \(AIM\)](#)
 - AIPs include two types of payments:
 - One-time upfront payment of \$250,000
 - Eight quarterly payments calculated per beneficiary (capped at 10,000) paid over 2 years

Eligibility and application:

- Must apply and be eligible to participate in the MSSP Basic track glidepath (under any level) and must apply to receive AIPs in conjunction with MSSP application process; applications to receive AIPs in PY 2024 will be made available during PY 2023
- Limited to ACOs that are **not a renewing or re-entering ACO**, designated as **low revenue**, AND designated as **inexperienced with performance-based risk**
 - CMS will monitor ACOs that receive AIPs to determine if they remain low revenue ACOs that are inexperienced with performance-based risk
- ACOs must submit a spend plan as part of the application for AIPs and publicly report the spend plan, payments received, and how AIPs are spent during each PY

Advance Investment Payments



Use of funds and recoupment:

- AIPs must be used to improve the quality and efficiency of care delivery by investing in:
 - (1) Increased staffing
 - (2) Health care infrastructure
 - (3) The provision of accountable care for underserved beneficiaries (may include addressing SDOH and/or HRSNs)
- AIPs **may not** be used for any expense that would not constitute a permitted use of funds, such as management/parent company profits, provider bonuses, or the provision of medical services covered by Medicare
- AIPs will be paid over the first two years of an agreement period and must be spent within the duration of the 5-year agreement period
 - Any unspent AIPs must be repaid to CMS at the end of the agreement period
- CMS will recoup AIPs from any shared savings earned by the ACO in any PY until CMS has recouped all AIPs, including in subsequent agreement periods
 - If an ACO does not earn shared savings in any agreement period, CMS would not recoup any AIPs
 - If an ACO terminates participation during the agreement in which it receives an AIP, the ACO must repay all AIPs received

Advance Investment Payments



Payment methodology:

- CMS proposes to calculate an ACO's quarterly payment amount prior to the start of each quarter based on the latest available assignment list, with payments equal to the sum of per beneficiary payments for up to 10,000 beneficiaries
- Per beneficiary payment amounts will vary based on a risk factors-based score calculated by CMS to provide higher payments for underserved beneficiaries
 - Beneficiaries dually-eligible for Medicare and Medicaid would receive a score of 100
 - Non-duals would receive a score (1-100) based on the ADI national percentile ranking of the beneficiary's primary address
 - For beneficiaries with insufficient data to score, CMS would impute a score of 50
 - For ACOs with more than 10,000 beneficiaries, CMS proposes to calculate the quarterly AIPs based on the 10,000 assigned beneficiaries with the highest risk factors-based scores
 - Table 42 outlines proposed per beneficiary payment amounts:

Risk factors-based score	1-24	25-34	35-44	45-54	55-64	65-74	75-84	85-100
Per beneficiary payment amount	\$0	\$20	\$24	\$28	\$32	\$36	\$40	\$45

- CMS includes several alternative proposals for comment on alternative indices to inform the risk factors-based score, calculating the quarterly payment amount, timing of quarterly payments, and varying the one-time upfront payment based on the ACO's population size and/or risk factors

Proposed Quality Changes



Proposed Quality Changes



Overview of Proposed Changes:

- Addition of an alternative, lower quality performance standard for those not meeting the higher standard to share in savings at the maximum shared savings rate
 - CMS also notes an error published in last year's rule regarding historic MIPS quality scores at the 30th & 40th percentile
- Favorable adjustments to calculations for shared losses for Enhanced Track ACOs who are not able to meet the quality performance standard
- Extension of incentives in place for reporting eCQMs/MIPS CQMs through 2024
- Introducing a new bonus opportunity for ACOs reporting eCQMs/MIPS CQMs and serving a large proportion of underserved communities
- Clarifying CMS may re-open financial determinations for ACOs due to MIPS scoring errors

Proposed Quality Changes



Quality Performance Standard Changes

- CMS proposes to adopt an alternative, lower quality performance standard for ACOs who fail to meet the higher performance standard required for sharing in savings at the maximum shared savings rate
- ACOs would be eligible for shared savings at a rate that is determined on a sliding scale based on their final quality score, if the ACO should fail to meet the prescribed quality performance standard to be eligible to share in the maximum shared savings rate
- The lower, alternative quality performance standard is:
 - A quality performance score equivalent to or higher than the 10th percentile of the individual measure performance benchmark on at least one of the four outcome measures in the APP measure set
- The ACO's final sharing rate would be a scaled rate that is calculated by multiplying the maximum sharing rate for the ACO's track/level by the ACO's quality performance score (including any health equity bonus points)

Proposed Quality Changes



Quality Performance Standard Changes

- Example: An ACO participating in Basic Track Level B met the minimum savings rate to quality for shared savings, and had a total quality score (including any health equity bonus points, if applicable) of 45 points. This is lower than the prescribed quality performance standard (30th percentile of MIPS quality performance category scores). The ACO did score higher than the individual measure benchmark for at least one of the 4 outcome measures in the measure set
- This ACO is not eligible to share in the maximum shared savings rate of 40% but is eligible to receive a scaled shared savings rate based on their final quality score:
 - 40% (maximum sharing rate for Basic Track Level B) \times 45% (final quality score) = final sharing rate of 18%

Proposed Quality Changes

Quality Performance Standard Changes

- CMS notes an error published in last year’s MPFS rules regarding historic MIPS quality scores at the 30th & 40th percentile for the quality performance standard – results in significantly lower scores
- CMS also provides historic scores for 2020

	2018 – 30 th percentile	2018- 40 th percentile	2019- 30 th percentile	2019- 40 th percentile	2020- 30 th percentile	2020- 40 th percentile
Published in 2022 MPFS rules	83.9	93.3	87.9	95.7		
Published in Proposed 2023 MPFS Rule	59.3	70.8	58.0	70.82	63.90	75.59

Proposed Quality Changes



- **Shared Loss Rate Calculations:** CMS proposes to alter shared loss rate calculations for Enhanced Track ACOs that do not meet the quality performance standard threshold, but meet the alternative threshold, to allow ACOs to receive a shared loss rate based on a sliding scale and tied to the final quality score, rather than automatically being subject to the maximum loss rate of 75 percent
- **Equity Bonus Points:** Proposes to establish a health equity adjustment that would provide quality bonus points to be added to an ACO's quality performance score when it delivers high quality care to underserved populations – if reporting eCQMs/MIPS CQMs
 - Up to 10 points, scaled based on quality score and proportion of beneficiaries from underserved neighborhoods (census block group w/ an ADI national percentile rank of 85 or higher)/dual eligibility)
 - Applies only to certain MSSP calculations

Proposed Quality Changes



MIPS Errors and ACO Financial Determinations

- CMS notes they have the sole discretion to make a correction to a prior PY determination of ACO financial results as a result of corrections made to MIPS quality performance category scores- this could cause CMS to reopen payment determinations due to MIPS scoring errors
- CMS notes they would reopen initial determinations of financial performance to account for any corrections that may have been made to MIPS quality performance category scores that affect shared savings eligibility/amounts, with no restrictions on the magnitude of the error or the number of ACOs affected
- In these cases CMS would seek to potentially adjust the shared savings payments to ACOs/loss recoupments for a subsequent performance year

Proposed Quality Changes

Benchmark changes:

- CMS proposes for 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) to be scored using flat percentage benchmarks for the 2022 performance year (and the 2023 PY)
- This results in 8 WI measures being scored for 2022 (retroactive policy)

Measure changes:

- There are no proposed changes to the MSSP measure sets, except for a measure name change for the claims-based measure, All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS measure. The new name is - Measure 484: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
- CMS seeks comment on the potential future inclusion of measures related to Screening for Social Drivers of Health and CAHPS questions specific to health disparities
- CMS also seeks comment on potential future inclusion of CAHPS questions related to price transparency

Proposed Quality Payment Program (QPP) Changes



MIPS Proposals



CMS proposes minimal MIPS changes for ACOs

- **Performance Category Weights:** Remain the same for 2023 as proposed for ACOs subject to MIPS
- **Performance Threshold:** CMS proposes to maintain a 75-point performance threshold for MIPS
 - Reminder- there is no exceptional performance threshold starting with the 2023 performance year (corresponding to the 2025 payment year) as the exceptional performance bonus has expired. This will result in minimal MIPS bonus opportunities
- **PI Changes:** The rule includes several small updates to the Promoting Interoperability Performance Category scoring methods and measures
- **RFIs on use of TEFCA and FHIR to transition to dQMs in the future:**
 - Requesting information on opportunities to incentivize participation in the Trusted Exchange Framework and Common Agreement (TEFCA) and on data standardization activities related to leveraging and advancing standards for digital data, as well as approaches to transition to FHIR eCQM reporting, as an initial step in the CMS transition to digital quality measurement

Advanced APMs



Advanced APM Bonus & QP Thresholds

- Performance year 2022 is the **final year** for ACOs to earn a 5 percent bonus paid in 2024
- QP Thresholds for 2023 are also set to increase to **75 percent** for the payment amount and **50 percent** for patient count
 - Partial QP Thresholds will be **50 percent** and **35 percent**

Annual Medicare Payment Adjustments for Advanced APMs									
Performance year*	2017	2018	2019	2020	2021	2022	2023	2024	
Payment year	2019	2020	2021	2022	2023	2024	2025	2026	
Annual Payment Update	+0.5%	0.0%					AAPMs: +0.75% Others: +0.25%		
Advanced APM Bonus	+5.0%					UNABLE TO EARN BONUS PAYMENTS			

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

Advanced APM Proposed Changes

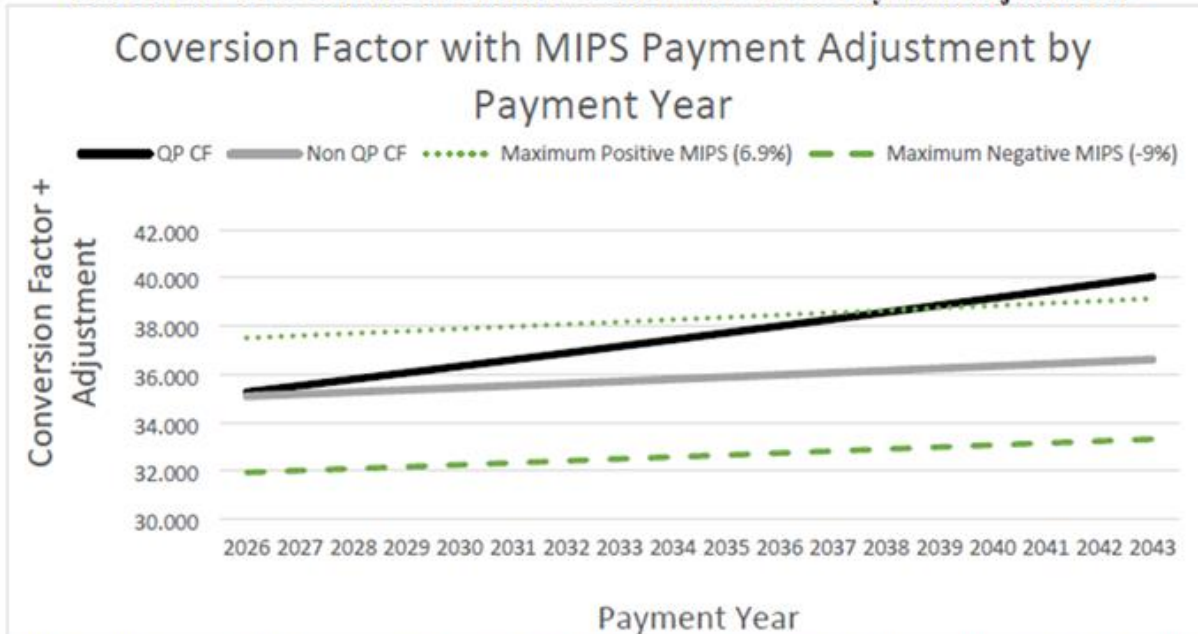


- CMS proposes to clarify that Advanced APM payment requirements can be met through the use of a single quality measure
- CMS proposes to make the 8 percent minimum for the Generally Applicable Nominal Risk standard for Advanced APMs permanent
- For 2023, CMS proposes to move up the cutoff date for QPs to verify non-payment information from November 1 to September 1, or 60 days from date of bonus payments
- **CMS is also requesting public comment on transitioning from the current APM entity level QP determination to an individual clinician determination process**
 - CMS believe the change would:
 - Reduce practice of APMs removing specialist from their participation list
 - Increase the number of eligible QP clinicians
 - Remove clinicians who become QPs for a year only because of their affiliation with an APM entity

CMS Concerns About QP Conversion Factor



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.

- CMS is concerned that current QPP incentives will limit participation in Advanced APMs
- Payment updates for advanced APMs will not be comparable to MIPS positive payment adjustment until 2038
- CMS projects **a drop of nearly 100,000 clinicians who qualify as a QP in 2023,** estimated 144,00-186,000 QPs
- **CMS is seeking public comments through an RFI in the proposed rule asking stakeholders about their organization's plans for future participation in Advanced APMs vs. MIPS**

MSSP Changes and Value in Health Care Act



H.R. 4587, the Value in Health Care Act	CY2023 MPFS Proposed Rule
50 Percent Shared Savings Rates	<ul style="list-style-type: none"> ✗ Not Addressed. CMS proposes to keep 40 percent shared saving rate established under Pathways for Success.
Modifying risk adjustment to 5 percent	<ul style="list-style-type: none"> ○ Partially Addressed w New Policy. CMS proposes to account for changes in ACOs' demographic risk scores before applying its 3 percent cap on clinical risk scores.
High-Low Revenue & Shared Savings Adjustments	<ul style="list-style-type: none"> ○ Partially Addressed w New Policy. While CMS will continue high-low revenue distinction established for ACOs under Pathways for Success, CMS proposes a new 7-year transition to risk for ACOs inexperienced with performance-based risk. Also makes the ENHANCED track optional for all ACOs.
Adjusting Benchmarks to Fix Rural Glitch	<ul style="list-style-type: none"> ○ Partially Addressed w New Policy. While CMS includes several positive changes that improve benchmarks for ACOs, it does not fully fix the rural glitch issue.
Advanced ACO Funding	<ul style="list-style-type: none"> ✓ New Policy. CMS proposes new advance investment payments, including a fixed upfront payment and quarterly payments for 2 years, for certain new "low revenue" ACOs inexperienced with performance-based risk that would be recouped through future shared savings.
GAO Report On Health Disparities	<ul style="list-style-type: none"> ✓ New Policy. CMS includes a new health equity adjustment for certain ACOs' quality scores and seeks comments on screening SODH through quality measures.

Advanced APM Changes and Value Act



H.R. 4587, the Value in Health Care Act	CY2023 MPFS Proposed Rule
Six Year Extension of AAPM Bonus	∅ Not Addressed. Needs to be updated by statute. CMS issued RFI to learn from stakeholders about the potential impact of bonus expiration on APM participation.
Addressing QP Threshold Increase	∅ Not Addressed. Needs to be updated by statute. CMS estimates current policy will result in nearly 100k less Advanced APM participants in 2023.
APM Model Overlap	∅ Not Addressed. CMS did not make any significant changes to overlap policy and further estimates that current incentives in the Quality Payment Program (QPP) will likely result in less Advanced APM participation due to better financial incentives/bonuses under MIPS.

Questions?



Thank you!



Please email advocacy@naacos.com with additional comments and questions.