



# Final 2023 Medicare Physician Fee Schedule Rule: *Key ACO Changes for 2023*



**November 14, 2022  
2:00 pm ET**

# Agenda

Welcome and Introductions

Review of the final CY2023 Medicare Physician Fee Schedule rule

- MSSP changes:
  - Glidepath to risk
  - Financial methodology
  - Assignment and burden reduction
  - Advance investment payments
  - Quality
- QPP changes:
  - 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.




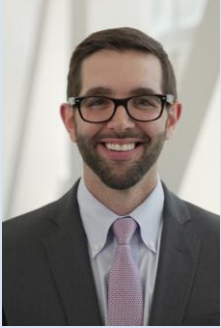



## We will take questions at the end of the program

At any time, please submit written questions using the **Questions tab** (not chat) on the dashboard

# Speakers



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

# Overview and Key Payment Changes





# Proposed 2023 MPFS Rule

- CY 2023 MPFS Final [Rule](#) Released November 1
- Several wins in final 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
  - ✓ 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](#)
- [Comments](#) on the proposed rule
- Email us your questions—[advocacy@naacos.com](mailto:advocacy@naacos.com)

## CMS Resources:

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

# Payment and E/M Updates



- Finalized 2023 Conversion Factor (CF) of \$33.06; 4.45% lower than the 2022 CF of \$34.61
  - Expiration of the one-time 3% payment increase provided by the Protecting Medicare and American Farmers from Sequester Cuts Act
  - MACRA Statutory Update of 0%
  - RVU Budget Neutrality adjustment of -1.5%
- Rebased and revised the Medicare Economic Index (MEI) to reflect more current market conditions faced by physicians
  - Geographic Practice Cost Index (GPCI) and PFS ratesetting will be updated with new 2017-based MEI cost weights beginning CY 2024
  - See Table 45: Final 2017-based MEI, 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

# Changes to Pathways to Success Glidepath to Risk



# Glidepath Changes



Inexperienced w/ risk = 7 years upside only

Currently participating in Level A/B = remainder of the agreement period in upside only

Enhanced Track Optional for all ACOs

# Glidepath Changes



## CMS finalizes changes to allow additional time in upside only models

- ACOs inexperienced w/ risk: Starting 1/1/2024, 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 remain eligible, ACOs are permitted another 5-year agreement period progressing through the Basic Track
    - If ineligible, the ACO would participate in Basic Track Level E for all 5 years of the second agreement period (or go to Enhanced)
- Enhanced Track now optional for all ACOs
- Table 56 in final rule outlines participation options

# Glidepath Changes



**Starting 1/1/2023 ACOs currently in Basic Track A/B can elect to continue in their current level for the remainder of their agreement**

## **PY 2023**

An ACO in Basic Level A or B may elect to remain in the same level it participated in for PY 2022 for the remainder of the agreement period

## **PY 2024**

An ACO w/ an agreement period beginning 1/1/2023 in Basic Level A or B may elect to remain in the same level it participated in for PY 2023 for the remainder of the agreement period

# Glidepath Changes



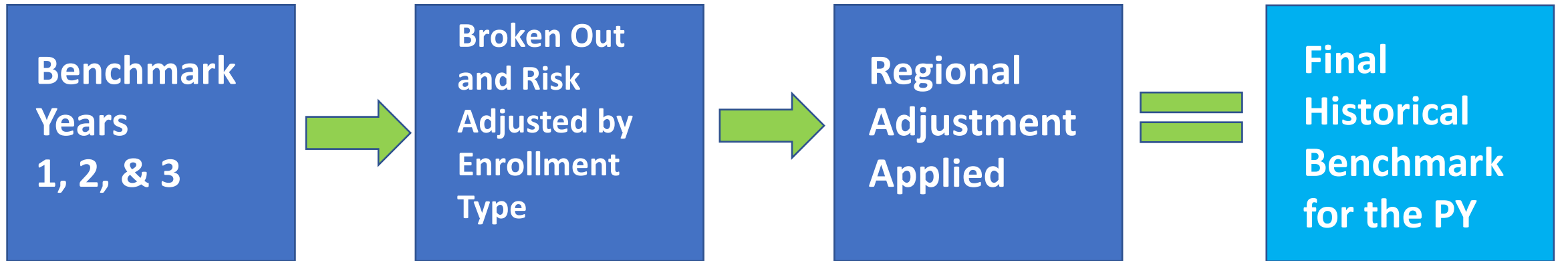
**CMS Monitoring:** CMS will monitor ACOs for changes to their ACO participant list, using a 5-year rolling lookback period (for example, PY 2020 through PY 2024, if PY 2025 were under review)

- If meet the definition of exp. w/ performance-based risk, the ACO can stay in their current level for the remainder of the performance year and must advance to Basic Level E at the start of the next performance period
- CMS will re-assess proposed participant lists each year
- Definition of risk amended to include only Levels C-E of Basic Track

# Financial Methodology



# 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](#)

# Financial Changes



## High-level take aways

Nearly all proposed changes were finalized as proposed

The “rural glitch” remains in effect, but CMS feels other finalized changes help reduce its impact

All finalized financial methodology changes are limited to new agreements beginning in 2024

No changes to account for COVID-19

High-low revenue distinction remains in place

# Three-Way Prospective Trend



Current way  
CMS  
updates  
benchmarks  
year to year

Previous  
Year's  
Benchmark



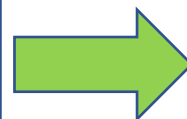
Retrospective  
National  
Assignable  
FFS Trend\*

Retrospective  
Regional  
FFS Trend\*



New  
Policy  
to Start  
in 2024

Previous  
Year's  
Benchmark



New Accountable  
Care Prospective  
Trend\*\*  
*1/3 of New BM*



Two-Way Blend\*  
Calculated the Same as Current Policy  
*2/3 of New Benchmark*

\*Varies by ACO

\*\*Same for all ACOs

# Three-Way Prospective Trend



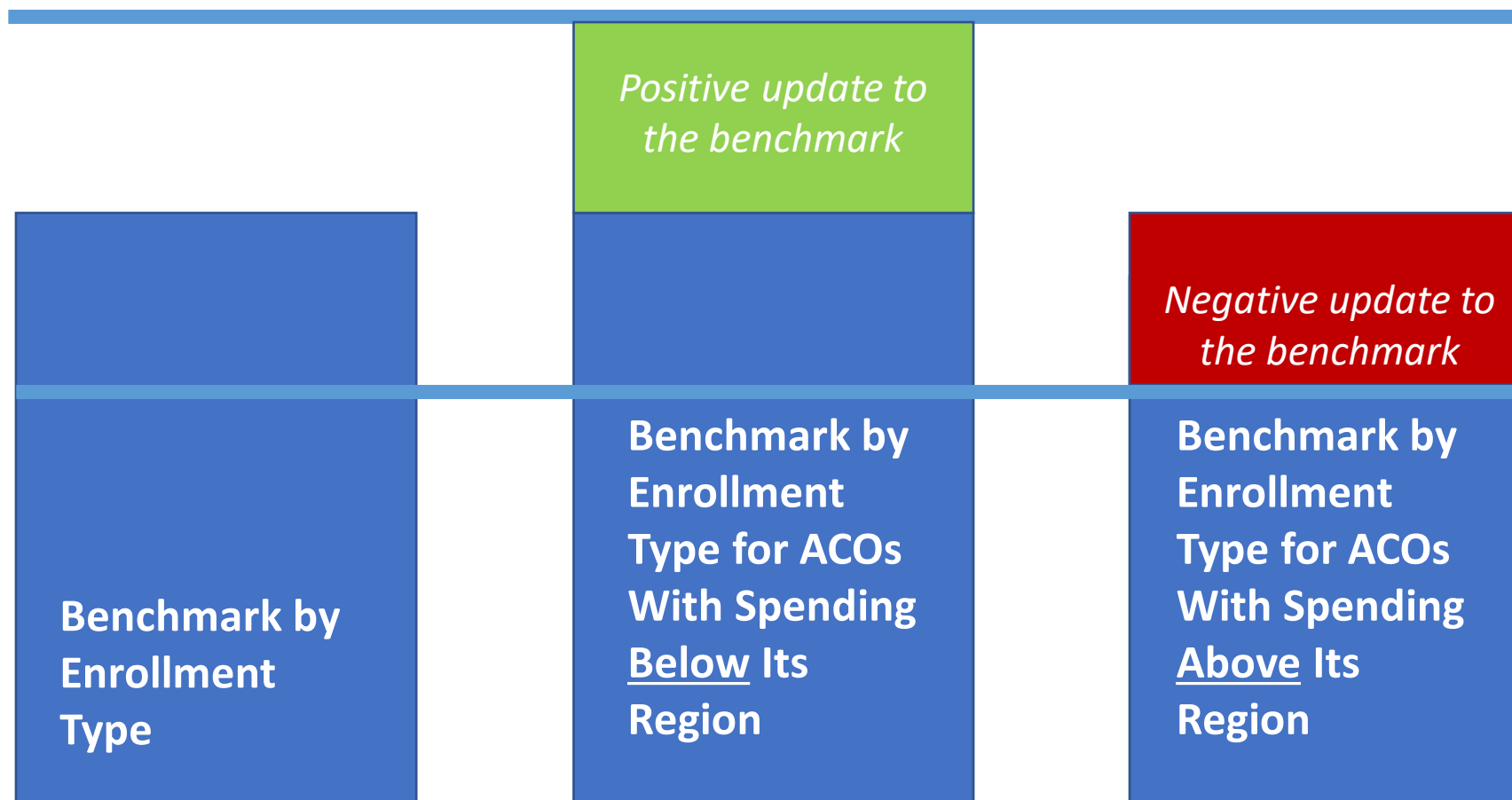
- **Key pieces of the Accountable Care Prospective Trend (ACPT)**

- Based on 5-year-projections by the CMS Actuary in per capita spending at the start of an ACO's agreement period. A modification of trend projections used for setting Medicare Advantage rates.
- Not adjusted for geographic differences in costs or prices.
- If an ACO generates losses under the three-way blend, CMS would recalculate an updated benchmark using the two-way national-regional blend and the ACO would pay the lesser of the two shared loss amounts
- Would take effect for new agreements starting in 2024
- CMS retains discretion to decrease the weight of the ACPT in the three-way blend
- CMS sees a three-way trend decoupling ACO benchmarks from FFS spending, provide more stability, and removing so-called "ratcheting effect"
  - "Infeasible" to project multi-year county-level spending projections

# Negative Regional Adjustment

+5% of national per capita spending (stays the same)

-5% of national per capita spending (old cap)



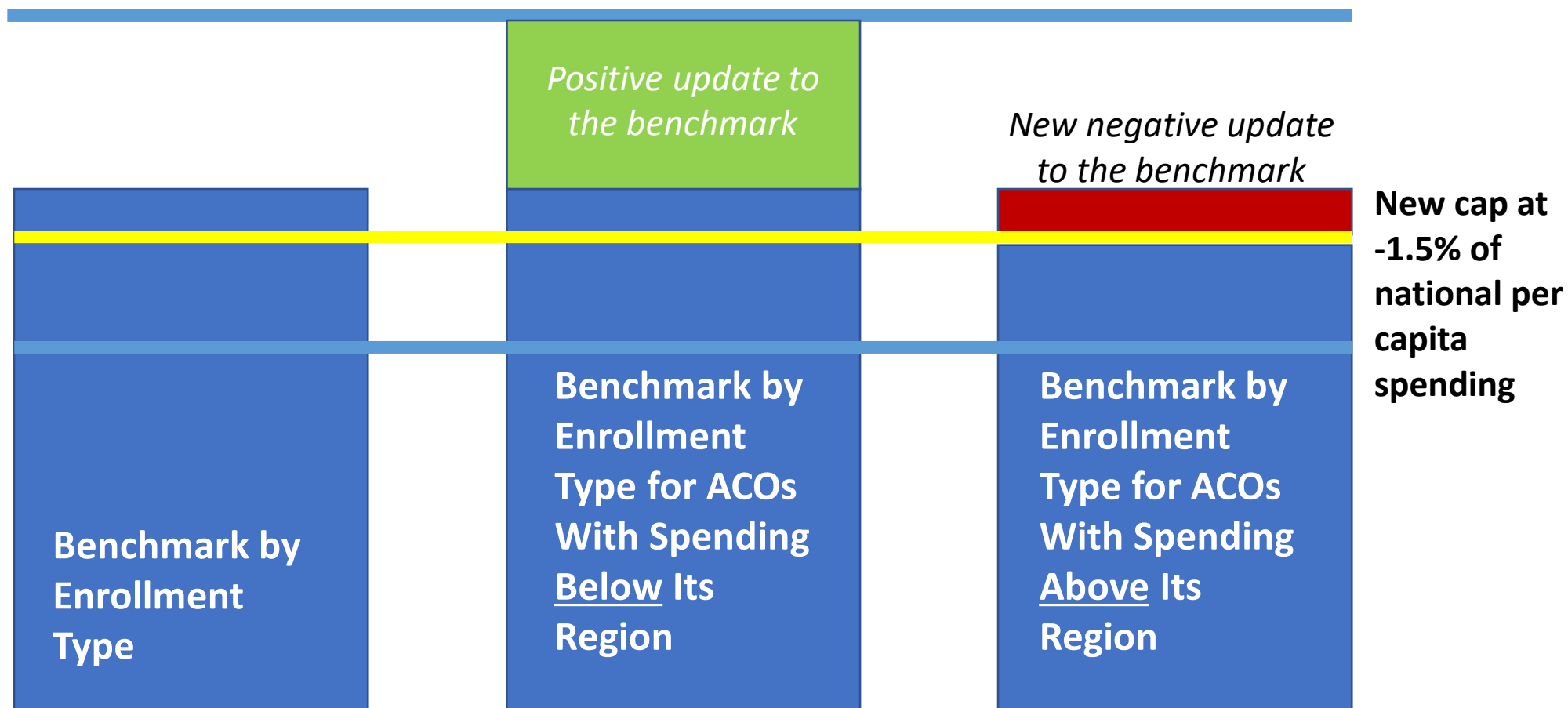
***Current Policy***

# Negative Regional Adjustment



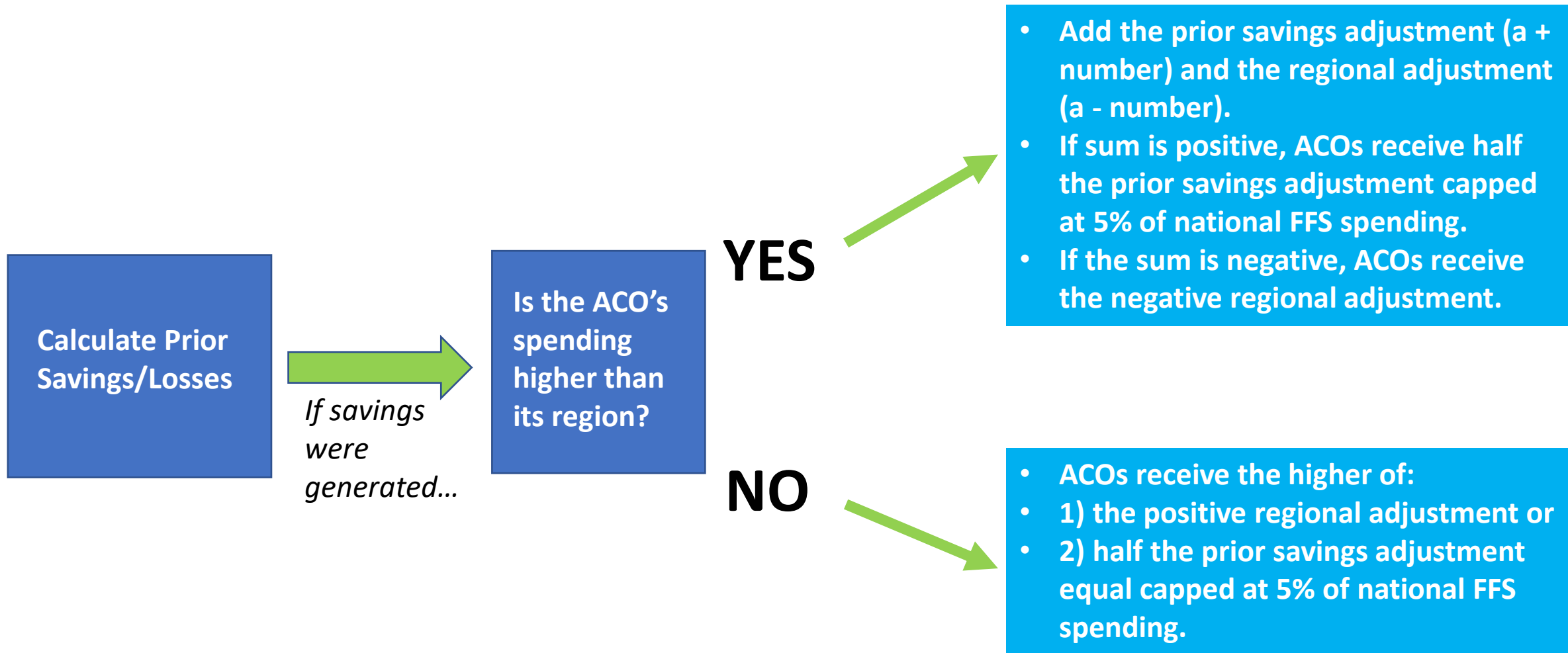
+5% of national per capita spending (stays the same)

-5% of national per capita spending (old cap)



**Finalized Changed.** This helps ACOs that have spending higher than its region. The regional adjustment can't hurt those ACOs as much.

# Prior Savings Adjustment



# More Shared Savings Opportunities

## Basic Track Low Revenue ACOs That Fall Below Their MSR

- Will allow low revenue ACOs in Basic Track to earn some savings if they fail to meet or exceed MSR

### Track A/B

Max savings rate of 20% if ACOs fail to exceed their MSR

### Track C/D/E

Max savings rate of 25% if ACOs fail to exceed their MSR

- Declined to expand to all ACOs, including high-revenue ACOs and those in the Enhanced Track

# Other Financial Changes



## **Risk adjustment change**

- Finalizes change to use ACOs' demographic risk scores before applying the 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

## **Regional adjustment under prospective assignment**

- Finalizes change to calculate regional spending using an off-set assignment window (October to September) that matches what is used for ACOs under 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

# Assignment and Burden Reduction



# Beneficiary Assignment



## CMS finalized changes to MSSP assignment as proposed:

- Add newly-finalized codes to the assignment list:
  - Prolonged nursing home services (G0317) and prolonged home services (G0318)
  - Chronic pain management (CPM) services (G3002 & G3003)
- Update the description of E/M Home Services (CPT codes 99341 through 99350) to remove the reference to “service modifier 12,” which expands the definition to include services provided in assisted living facilities, group homes, custodial care facilities, and residential substance use treatment facilities
- Create new policies for using CMS Certification Numbers (CCNs) in assignment
  - Determine CCNs for all FQHCs, RHCs, CAHs and ETA hospitals enrolled under an ACO participant TIN at the start of and periodically during the PY and include newly-enrolled CCNs in program operations
  - 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



## CMS finalized policies to reduce administrative burden:

- Remove the requirement to submit marketing materials to CMS before use (*Must be provided upon request by CMS*)
- Remove the requirement for ACOs to submit plan narratives as part of the SNF 3-day waiver application (*Must be provided upon request by CMS*)
- Modify MSSP data sharing regulations so ACOs acting as organized health care arrangements (OHCA) may request aggregate reports and beneficiary identifiable claims data from CMS
- Reduce the frequency of the standard beneficiary notice to **once per 5-year agreement period**, rather than annually
- Create a **new follow-up communication** requirement in conjunction with the standard notice
  - Must be provided within 180 days of providing the notice or at the next primary care visit
  - May be verbal or written (including via email or patient portal) and must include a meaningful opportunity for beneficiaries to ask questions
  - ACOs must document how the communication is implemented

# Advance Investment Payments



# Advance Investment Payments



**CMS finalized policies to provide advance shared savings payments, referred to as advance investment payments (AIPs) to certain MSSP ACOs**

- NAACOS has long [advocated for](#) CMS to make upfront funding available to ACOs, which will further our shared goals of expanding access to accountable care and advancing efforts to address health equity.

**Modeled after  
the ACO  
Investment  
Model (AIM)**

**Upfront lump sum  
payment + per  
beneficiary payments  
over first 2  
performance years**

**Beginning January  
1, 2024; First  
application cycle  
to open during  
PY 2023**

# Advance Investment Payments



## Eligibility and application:

- Limited to new ACOs (**not a renewing or re-entering ACO**) designated as **low revenue**, AND designated as **inexperienced with performance-based risk**
  - NAACOS has urged CMS to expand eligibility criteria to include more types of ACOs and providers
- Must apply and be eligible to participate in the MSSP Basic Track (under any level) and must apply to receive AIPs in conjunction with MSSP application process
  - CMS will provide additional guidance on applications to receive AIPs in PY 2024 during PY 2023
- 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

## Duration:

- 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

# 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  
*(including training/education for existing staff)*
  - ② Health care provider infrastructure
  - ③ The provision of accountable care for underserved beneficiaries  
*(including addressing SDOH)*
- 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
  - CMS will provide additional guidance on allowable and prohibited uses of AIPs
- 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:

**One-time upfront payment**  
**\$250,000**



**Eight quarterly payments**  
**\$\$ varies = sum of per beneficiary payments for up to 10,000 assigned beneficiaries**

- CMS will calculate an ACO’s quarterly payment amount prior to the start of each quarter based on the latest available assignment list
- Table 51 outlines the advance investment payment schedule:

	Jan. PY 1	Apr. PY 1	Jul. PY 1	Oct. PY 1	Jan. PY 2	Apr. PY 2	Jul. PY 2	Oct. PY 2
Payment type	One-time payment; Quarterly payment	Quarterly payment	Quarterly payment	Quarterly payment	Quarterly payment	Quarterly payment	Quarterly payment	Quarterly payment

- Per beneficiary payment amounts will vary based on a risk factors-based score calculated by CMS to provide higher payments for underserved beneficiaries
- For ACOs with more than 10,000 beneficiaries, CMS will calculate the quarterly AIPs based on the 10,000 assigned beneficiaries with the highest risk factors-based scores

# Advance Investment Payments



## Calculating the risk factors-based score:

1. Beneficiaries dually-eligible for Medicare and Medicaid receive a score of 100 (out of 100)
  2. Beneficiaries enrolled in the Medicare Part D low-income subsidy (LIS) receive a score of 100
  3. Beneficiaries not dually-eligible for Medicaid and without Part D LIS enrollment receive a score (1-100) based on the Area Deprivation Index (ADI) national percentile ranking of the beneficiary's primary address
  4. Beneficiaries with insufficient data to assign a score receive imputed score of 50
- Despite many commenters (including NAACOS) raising concerns with use of ADI national percentile ranks and offering a variety of alternatives, CMS finalized the use of ADI in the risk factors-based score as proposed
  - Table 53 outlines finalized 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

# Quality Changes



# Quality Standard



CMS establishes 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



Alternative quality performance standard:

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

## Alternative Quality Standard Calculation Example

- ✓ ACO in Basic Track Level B met the MSR to quality for shared savings, w/ a quality score of 45 points. This is lower than the prescribed quality performance standard (30<sup>th</sup> 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
- ✓ ACO is not eligible to share in the maximum shared savings rate of 40% but is eligible to receive a scaled savings rate based on the final quality score:
  - $40\% \text{ (maximum sharing rate for Basic Track Level B)} \times 45\% \text{ (final quality score)} = \text{final sharing rate of } 18\%$
  - NAACOS advocated for a return to a more balanced approach to determining shared savings and we are pleased to see these changes

# Quality Standard



Quality Performance Category Scores	30 <sup>th</sup> percentile	40 <sup>th</sup> percentile
2018	59.3	70.8
2019	58.0	70.82
2020	63.90	75.59
2021	61.7	77.8

## Shared Loss Rate Calculations – Enhanced Track ACOs

- CMS alters shared loss rate calculations for Enhanced Track ACOs that do not meet the quality performance standard threshold, but meet the alternative standard
- Allows ACOs to receive a shared loss rate based on a sliding scale tied to the final quality score, rather than automatically being subject to the maximum loss rate of 75 percent

# Equity Bonus

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New health equity adjustment will provide bonus points to an ACO's quality score when it delivers high quality care to underserved populations

Available for PY 2023 & subsequent years for ACOs reporting eCQM/MIPS CQM

CMS will share info. on these calculations in reconciliation reports and will share quarterly info on certain beneficiary-identifiable data on dual eligibility, LIS and ADI national percentile rank

# Equity Bonus



## Calculating the equity bonus:

**Performance scaler** – ACO quality score compared to others reporting eCQM/MIPS CQM for e/ measure (up to 24 points)

- CMS groups performance to high, middle and low performers and assigns point for e/ category

**Underserved multiplier** – proportion of assigned beneficiaries (higher of)

1. Residing in a census block group with ADI national percentile rank of 85 or higher
  2. Dually eligible for Medicare and Medicaid
  3. Enrolled in the Part D Low Income Subsidy (LIS)
- ACOs' performance measure scaler is multiplied by the ACO's underserved multiplier to calculate health equity adjustment

## MIPS Errors and ACO Financial Determinations

- CMS has sole discretion to make a correction to a prior PY determination of ACO financial results as a result of corrections made to MIPS scores- this could cause CMS to reopen payment determinations due to MIPS scoring errors
- CMS would adjust the shared savings payments/loss recoupments to ACOs for a subsequent performance year when possible
- Must still meet requirements to repay shared losses w/in 90 days
- NAACOS will monitor this process and the impact of MIPS scoring errors on ACO payment determinations and advocate for minimal disruption to ACOs

# Quality Measure Changes



Quality measure sets remain the same for 2023 for ACOs (see Table 61)

- Slight measure name change for All Cause Unplanned Admissions for Multiple Chronic Conditions measure
- Data completeness standard will increase from 70% to 75% in 2024

Measure benchmark updates

- Tobacco Use Screening and Cessation Intervention and Screening for Depression and Follow-up Plan will be scored using flat percentage benchmarks for PY 2022 and 2023

# 2023 Quality Payment Program (QPP) Changes



# 2023 MIPS Req's



## Performance Category Weights

- Remain the same for 2023 for ACOs subject to MIPS

## Performance Threshold

- CMS maintains 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)
  - This will result in minimal MIPS bonus opportunities

## Promoting Interoperability

- Minor updates to the PI Performance Category scoring methods and measures – refer to Table 95 in final rule for overview

# Advanced APMs



# Advanced APMs



## Policy Changes

- Performance year 2022 is the **final year** for ACOs to earn a 5 percent incentive payment paid in 2024
- QP thresholds under current law will increase in 2023 to **75 percent** for the payment amount and **50 percent** for patient count
  - Partial QP Thresholds will be **50 percent** and **35 percent**
- 8% risk standard made permanent
- September 1 is new deadline for QPs to verify banking information for next year's APM incentive payments
- Clarifies payment requirements can be met using a single quality measure

## Requests for Information

- CMS remains concerned about the current incentive structure of the QPP and how that will impact participation in value-based care models
  - CMS asked stakeholders about how the current QPP incentives would impact future participation in Advanced APMs and MIPS
    - CMS is projecting up to 80,000-100,000 fewer QPs in 2023
  - CMS also requested comments on a future transition from the current APM entity level QP determination to an individual clinician determination process

# Advanced APM Stakeholder Advocacy



The Alliance is urging Congress to extend Medicare APM incentives, and freeze qualifying thresholds, for physicians, other clinicians, medical groups, and health systems to prioritize care that generate better outcomes for patients. Learn more at: <https://valuebasedcare.org>

## Fall Advocacy Updates

- ✓ Stakeholder letter with over 800 organizations asking Congress to pass an extension of APM incentives
- ✓ Meetings with key Congressional leaders
- ✓ Congressional briefing for lawmakers and staff
- ✓ Bipartisan letter of support from 44 House members

**❑ Contact your lawmakers today! Ask them to support an extension of the 5 Percent APM incentives**

<https://www.naacos.com/take-action>

ALLIANCE FOR  
VALUE-BASED+  
PATIENT CARE



# *Questions?*



# Thank you!



Please email [advocacy@naacos.com](mailto:advocacy@naacos.com) with additional comments and questions.