NAACOS Analysis of the Final 2023 Medicare Physician Fee Schedule

Executive Summary

On November 1, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2023 Medicare Physician Fee Schedule (MPFS) Final Rule. This 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 finalized policies impacting ACOs. The rule is summarized in several fact sheets provided by CMS: MPFS Fact Sheet, MSSP Fact Sheet and Quality Payment Program (QPP) Fact Sheet.

NAACOS provided detailed comments in response to the proposed 2023 MPFS rule, with key input from members. Most policies were finalized as proposed.

Medicare Shared Savings Program Policies

- Change the "Pathways to Success" glidepath to allow more time before advancing to risk for certain ACOs*
- Incorporate a prospectively projected administrative growth factor into a new three-way blend with national and regional growth rates to update an ACO's historical benchmark for each performance year
- Account for an ACO's prior savings in rebased benchmarks to help mitigate the lowering of an ACO's benchmark over time
- Reduce the cap on negative regional adjustments from -5 percent to -1.5 percent
- Revise how CMS applies the existing 3 percent cap on hierarchical condition code (HCC) risk score growth
- Allow low revenue ACOs in the Basic Track more opportunities to earn shared savings
- Change the quality scoring approach to allow more ACOs to achieve a portion of savings*
- Add a health equity adjustment increase to quality scores for ACOs serving high proportions of underserved beneficiaries
- Provide advance investment payments to certain ACOs*

*Denotes policies for which NAACOS has long advocated

Medicare Physician Payment Policies

- Decrease the Medicare conversion factor from $34.61 to $33.06
- Update other evaluation and management (E/M) visits to reflect time spent or medical decision making
- Implement telehealth provisions established in the Consolidated Appropriations Act (CAA) of 2022

MEDICARE SHARED SAVINGS PROGRAM

Pathways to Success Glidepath to Risk

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

- Providing up to seven years in upside-only tracks for ACOs inexperienced with performance-based risk
- Allowing ACOs currently in upside-only tracks (Tracks A and B) to remain in upside-only for the duration of their agreement
- Making the Enhanced Track optional for all ACOs

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

ACOs Inexperienced with Risk

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

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

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

ACOs continuing to meet the definition of inexperienced with performance-based risk may enter a second agreement period in the Basic Track's glide path if the following criteria are met:

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

In the proposed rule CMS discussed, but did not finalize, an alternate proposal that would provide low revenue ACOs with no experience with performance-based risk up to 12 years of participation in upside-only before requiring the ACO to bear risk.

CMS Monitoring

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

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

ACOs Currently Participating in Basic Track Levels A, B

CMS finalized a policy to allow ACOs currently participating in Basic Track Level A or B the option to remain in the upside-only Track for the duration of the agreement period beginning on January 1, 2023. Specifically, for 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. For PY 2024, an ACO with 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.

Enhanced Track Optional

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

Table 56, Proposed Participation Options, in the final rule outlines the finalized participation options and glide path changes.

Financial Methodology

In the final rule, CMS made only a couple of minor technical changes to its proposals, which included several changes to the way ACO benchmarks are set, updated, and risk adjusted both at the start of an agreement and over the course of it. While we greatly appreciate that CMS acknowledged the “ratchet effect” and overall believe the net impact of finalized changes will help encourage ACO participation, we

have concerns about the unintended consequences of some of the finalized changes. NAACOS has long advocated for a fairer, more accurate financial methodology for ACOs. Specifically, we have requested that CMS fix the "rural glitch" by removing ACO-assigned beneficiaries from the regional reference population, increase risk score caps to +/-5 percent, and apply risk score caps to both the ACO and the region. CMS did not make any of these changes in the proposed rule; however, several positive adjustments are included. We are pleased that several finalized changes will help create the fairer, more accurate financial benchmarks, as NAACOS has long advocated.

Addition of a Prospective Update Factor

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

Two-way blend = (National Update Factor x National Weight) + (Regional Update Factor x (1 – National Weight))
Three-way blend = [PY1 ACPT x (1/3)] + [PY1 Two-Way Blend x (2/3)]

CMS notes that adding this prospective growth factor would insulate an ACO's benchmark from any savings that occur as a result of ACOs' work. The agency does not address the "rural glitch," which occurs when an ACO lowers its own benchmarks by lowering the spending of its region. However, CMS indicates its proposal would achieve the same effect as removing ACO-assigned beneficiaries from the regional reference population. In theory, this new three-way blend would allow benchmarks to grow higher than actual spending growth rates, which can be slowed by ACOs. This possibility of both higher benchmarks and greater savings opportunities would entice ACOs to both join and remain in MSSP.

CMS proposes to base the ACPT on the United States Per Capita Cost, which is already calculated by the CMS Actuary and used to base annual rate updates in Medicare Advantage. The ACPT would exclude payments made for indirect medical education, disproportionate share hospitals, uncompensated care, and new payments for Indian Health Service hospitals and hospitals located in Puerto Rico. CMS would calculate ACPT projections at the start of an ACO's five-year agreement period. These projections are expected to be published in the spring of the first performance year. If projections are not uniform over the five-year period, the ACPT could be two or more numbers.

CMS declined to accept NAACOS' proposed revisions to the new policy, which included using the ACPT as the national component of the current two-way trend adjustment, rather than observed national FFS spending. NAACOS argued it was too difficult to project national spending over five years and that there was too much regional variation in spending to have a single national update factor. According to NAACOS' analysis as many as a third of ACOs would see lower benchmarks under the three-way trend

because spending in their region would exceed the national ACPT update. CMS ran additional analysis estimating the use of ACPT over 2007–2016 and found minimal disruption to ACOs over long periods of time. As CMS reiterated in the final rule, use of the ACPT is viewed as critical to the agency's goal of having all Medicare FFS beneficiaries in an accountable care arrangement by 2030.

If an ACO generates losses under the three-way blend, CMS will recalculate an updated benchmark using the two-way national-regional blend. CMS will then use the lesser shared loss amount for an ACO's repayment responsibility and resulting financial performance monitoring policy. If the ACO generates losses under the three-way blend but savings under the two-way blend, the ACO will not be responsible for shared losses nor eligible for shared savings even if the ACOs minimum savings rate (MSR) was exceeded. CMS also declined to accept NAACOS' proposal to give ACOs the higher of the benchmark calculated under either the current two-way trend or the proposed three-way trend. CMS said in the final rule that giving ACOs the higher of those two would reward ACOs when they may not have improved care or efficiency, which would inflate shared savings payments.

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

Comment Solicitation on Incorporating Administrative Benchmarks

CMS also sought feedback on how it can implement a prospective, administratively set annual growth rate to update benchmarks. This would be a departure from updating ACO benchmarks on actual FFS spending growth in the ACOs region and nationally. The approach to updating benchmarks that CMS has used since the program began would systematically lower benchmarks over time as ACOs lower the spending growth of its patients. This "ratcheting" effect has been raised as a point of concern by both the Medicare Payment Advisory Commission (MedPAC) and other health policy thought leaders.

Accounting for an ACO's Prior Savings

As supported by NAACOS, CMS finalized its proposal to account for prior savings when establishing benchmarks for renewing and re-entering ACOs for agreement periods beginning in 2024. CMS states that the change will help further mitigate any ratcheting effect that occurs when ACO benchmarks are rebased. It will also help offset of the rural glitch, where an ACO lowers its benchmark when it lowers the spending on its region through its own assigned patients.

CMS will calculate the simple average per capita savings or losses generated by an ACO during the three years that immediately precede the start of the performance period, the same three years that constitute its baseline. For these calculations, CMS will use all savings generated, not just savings that meet or exceed an ACO's MSR for that performance year. If an ACO is not eligible to receive a prior savings adjustment, the ACO will receive the regional adjustment to its benchmark. For re-entering ACOs, CMS will calculate prior savings on the performance of the ACO in which 50 percent or more of the ACO participants previously participated.

CMS had included a similar "prior savings adjustment" for ACOs starting agreements in 2016 but quickly reversed that policy the following year after it started incorporating regional adjustments into

benchmarks. The agency felt at the time that benchmarks would "become overly inflated for some ACOs" benefiting from the regional adjustment. CMS states that this concern remains. To account for this, CMS will adjust prior savings amount depending on whether an ACO has higher or lower spending than its region.

- For ACOs with spending lower than the region. CMS will apply the higher of either (1) an ACO's positive regional adjustment or (2) a prior savings adjustment equal to the lesser of – (i) 50 percent of its prorated positive average per capita prior savings and (ii) 5 percent of national per capita FFS expenditures for assignable beneficiaries. Halving the prior savings adjustment accounts for ACOs' shared savings rates.
- For ACOs with spending higher than its region. CMS will add the prior savings adjustment (which will be a positive number) and the regional adjustment (which will be a negative number). If sum is positive, the ACO will receive half the prior savings adjustment capped at 5 percent of national FFS spending. If the sum is negative, ACOs receive the negative regional adjustment.

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

CMS declined to accept NAACOS' recommendations to modify the cap on the prior savings adjustment, which would limit the policy change's impact on both highly efficient ACOs and ACOs who serve sicker populations. CMS said in the final rule that it believes its approach to limit the prior savings adjustment to 5 percent of national FFS spending "strikes an appropriate balance" between limiting the ratcheting effect on ACOs and safeguarding Medicare spending from excessive shared savings payments.

Reducing the Impact of a Negative Regional Adjustment

As supported by NAACOS, CMS finalized a reduction in the cap on negative regional adjustments from -5 percent of national per capita FFS spending to -1.5 percent for agreement periods beginning in 2024. This helps ACOs that have spending higher than their region and would receive a higher benchmark after the regional adjustment. CMS will keep the upward cap of +5 percent for ACOs that have lower spending than their region.

In conjunction, CMS finalized its proposal to apply an offset factor to the negative regional adjustment based on the proportion of an ACO's dual eligible beneficiaries or its weighted-average HCC risk score increases. Therefore, the higher an ACO's proportion of dual eligible beneficiaries or the higher its risk score, the larger its overall negative regional adjustment would be reduced. CMS included one minor correction in an error of the description of the methodology in the proposed rule. When calculating the weighted average prospective HCC risk score for BY3 across the four Medicare enrollment types, the weight applied to the prospective HCC risk score for BY3 for each enrollment type is equal to the product of the BY3 per capita expenditures for that enrollment type and the BY3 person years for that enrollment type.

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

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

Risk Adjustment Changes

CMS finalized its proposal to account for changes in demographic risk scores for an ACO's assigned population between BY3 and the applicable performance year before applying the 3 percent cap on positive HCC scores beginning in 2024. Under the new policy, the +3 percent cap will apply in aggregate across the four enrollment types (ESRD, disabled, aged/dual eligible, and aged/non-dual eligible) after CMS accounts for changes in demographic risk scores, which do not change and are not subject to coding intensity. For example, if an ACO's demographic risk score was 1.026, then the new aggregate cap would be 1.056 or the demographic risk score plus the 0.03 growth that CMS allows. While CMS will calculate a single cap level based on demographic risk scores for the four enrollment types, it will only apply the risk score cap for a particular enrollment type if the aggregate growth in HCC risk scores exceeds the value of the cap. This makes it less likely that risk scores for Medicare enrollment types with smaller populations (typically ESRD, disabled, and dual eligible beneficiaries) would be subject to the cap.

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

CMS included one minor correction in an error of the description of the methodology in weighted average demographic and prospective HCC risk scores. The weights applied will be equal to the per capita historical benchmark expenditures for that enrollment type multiplied by the ACO's performance year assigned beneficiary person years for that enrollment type (not multiplied by the ACO's BY3 assigned beneficiary person years for that enrollment type as previously erroneously stated).

Additional Shared Savings Opportunities for Low Revenue ACOs Below MSR

CMS finalized without modifications its proposal to allow low revenue ACOs in the Basic Track the opportunity to earn some shared savings even if the ACO fails to meet or exceed its MSR. Qualifying ACOs are eligible for half of their maximum shared savings rate, so changes are as follows:

Risk Level	**Maximum Shared Savings Rate if the MSR is Exceeded**	**Maximum Shared Savings Rate if the MSR is NOT Exceeded**
Basic Levels A and B	40%	20%

Basic Levels C, D, and E	50%	25%

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

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

As CMS explains, this policy helps incentivize smaller, newer, more resource stricken ACOs to stay in the program and help the administration achieve its goal for 100 percent of patients to be covered by accountable care models. According to NAACOS analysis, a large number of ACOs generated savings for CMS but not enough to earned shared savings. This included 16 percent of MSSP ACOs in 2020, 22 percent in 2019, and 29 percent in 2018.

Calculating the Regional Adjustment Under Prospective Assignment

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

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

CMS notes in the final rule that this creates an unintentional bias for ACOs under prospective assignment, making benchmarks 0.2 percent to 2.0 percent higher than they would have been if the regional adjustment were based on an offset assignment window. The median estimated bias was 1.0 percent. This bias grew under Pathways as more ACOs began receiving regional adjustments.

COVID-19 Effects

While CMS did not propose any changes to MSSP's benchmarking methodology to account for the COVID-19 pandemic, the agency vowed to continue to monitor the impact of the public health emergency (PHE) for COVID-19 on MSSP to determine if future changes are needed to mitigate any unintended consequences of the pandemic. CMS' analysis of current data indicates that spending rebounded in 2021 and that averaging 2020 and 2021 represents a "reasonable basis" on which to base benchmarks. Therefore, when benchmarks include both 2020 and 2021 (as it would for ACOs with new performance agreements in 2023), CMS believes the average of both years represents for a fair assessment on which to set future spending targets. Additional update factors such as the current national-regional trend will also help mitigate any impact of COVID-19.

Removing Indian Health Service and Puerto Rican Hospitals

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

Advance Investment Payments

As part of its efforts to grow participation in accountable care models and advance equity, CMS finalized new policies to provide certain MSSP ACOs advance shared savings payments, termed advance investment payments (AIPs) beginning in the 2024 performance year. CMS acknowledges that smaller providers without access to capital and those serving underserved populations may not be able to make the necessary upfront investments to begin an ACO. NAACOS has called for such investments as a strategy to enable ACOs to effectively operate in under-resourced communities, close gaps in health equity, and address social drivers of health (SDOH). Largely modeled after the successes of the ACO Investment Model (AIM), AIPs will provide funding over the first two years of an ACO's agreement period, which will be recouped by CMS through any shared savings earned by the ACO.

Eligibility and Application

CMS finalized as proposed policies to limit eligibility to new (not renewing or re-entering) ACOs designated as low revenue and inexperienced with performance-based risk Medicare ACO initiatives that have applied and are eligible to participate in any level of the Basic Track. CMS will exclude all Parts A and B payments for beneficiaries' COVID-19 treatment episodes from expenditure and revenue calculations when determining eligibility for AIPs. ACOs will be required to apply for AIPs in conjunction with the annual MSSP application cycle, with the initial application cycle taking place in 2023 for a January 1, 2024, start date. CMS will provide preliminary information to applicant ACOs about eligibility to receive AIPs during the MSSP Phase 1 application cycle requests for information. As part of the application, an ACO will be required to submit a spend plan detailing how the ACO will spend the AIPs during the agreement period and the amounts that will be spent on various categories of goods and services and stating that the ACO has established a separate account for the deposit and expenditure of AIPs. CMS clarifies in this final rule that the agency will provide detailed guidance regarding the PY 2024 application process, including spend plan development, and that there will be a feedback process to allow ACO applicants to revise or clarify applications if needed.

Duration and use of AIPs

CMS finalized as proposed that AIPs will be paid over the first two years of an ACO's agreement period and that all AIPs must be spent within the five-year agreement period. Any unspent AIPs must be repaid to CMS at the end of the agreement period in which AIPs are received. CMS finalized, without change, proposed policies for the use and management of AIPs, including public reporting requirements. ACOs that receive AIPs will be required to publicly report the spend plan submitted during the application process, the dollar amount of AIPs received, and itemized spending of AIPs during each performance year. CMS will provide guidance for reporting the AIP spend plan and usage of AIP funds on the ACO's public reporting webpage. CMS will also require that an ACO receiving AIPs must establish and maintain a separate designated account for the deposit and expenditure of all AIPs to promote transparency and enable CMS to monitor ACOs' progress toward implementing the spend plan.

CMS notes that while regulations do not require an ACO to spend shared savings in a particular way, the agency will limit the use of AIPs to investments in three specified categories: increased staffing, health care provider infrastructure, and the provision of accountable care for underserved beneficiaries, including SDOH strategies. CMS will also prohibit the use of AIPs for any non-permitted expenses such as management/parent company profits, salary augmentation or bonuses, the provision of medical services covered by Medicare, or to pay back shared losses. CMS has provided several examples of permitted uses within each of the three categories of permitted uses, noting that the categories are intended to be broad and provide ACOs with flexibility in how AIPs are used to meet the greatest needs of their patients. In the final rule, CMS clarifies that training and education for existing staff would constitute a permitted use of funds and that the agency will provide additional sub-regulatory program guidance on the allowable and prohibited uses of AIPs.

Payment Methodology

CMS finalized, with slight modification, policies for calculating AIP amounts. AIPs will be comprised of two types of payments: a one-time upfront payment of $250,000 and eight quarterly payments calculated per beneficiary for up to 10,000 beneficiaries.

AIPs will include quarterly per beneficiary payments, rather than monthly or yearly payments, to balance the benefits of predictable cash flow with the administrative costs of calculating payments. CMS finalized the proposed approach to calculate quarterly AIP amounts prior to the start of each quarter using the latest available assignment list and to disburse quarterly AIPs at the beginning of each of the first eight quarters of the ACO's participation agreement. CMS outlines the finalized advance investment payment schedule in Table 51.

TABLE 51: Advance Investment Payment Schedule

	January; Performance Year (PY) 1	April; PY 1	July; PY 1	October; PY 1	January; PY 2	April; PY 2	July; PY 2	October; PY 2
Payment type	One-Time Payment; Quarterly Payment	Quarterly Payment	Quarterly Payment	Quarterly Payment	Quarterly Payment	Quarterly Payment	Quarterly Payment	Quarterly Payment

As finalized, CMS will calculate the quarterly payments by summing the per beneficiary payments for up to 10,000 beneficiaries. The per beneficiary amount will vary for each beneficiary based on a risk factors-based score calculated by CMS. As proposed, a beneficiary's risk factors-based score will be informed by dual eligibility status (DES) and the Area Deprivation Index (ADI) national percentile ranking of the census block group of the beneficiary's primary address. In the final rule, CMS added beneficiaries' enrollment in the Medicare Part D low-income subsidy (LIS) as a factor in determining beneficiaries' risk factors-based scores, which NAACOS advocated for. This approach is intended to reflect the variable operating costs related to the risk factors of an ACO's assigned beneficiaries and adequately support the provision of accountable care in underserved communities. As finalized, CMS will calculate an ACO's quarterly payment amounts using the following steps:

1. Determine the ACO's assigned beneficiary population using the latest available assignment list based on the certified ACO participant list for the relevant performance year.
2. Assign each beneficiary a risk factors-based score:
    a. Beneficiaries dually eligible for Medicare and Medicaid will be assigned a score of 100 (out of 100).
    b. Beneficiaries with at least one month of Part D LIS enrollment during the 12-month window corresponding with assignment window used for preliminary prospective assignment with retrospective reconciliation will be assigned a score of 100.
    c. Beneficiaries not dually eligible and not enrolled in the Part D LIS will be assigned a score (1–100) equal to the ADI national percentile rank of the census block group corresponding to the beneficiary's primary mailing address.
    d. For beneficiaries with insufficient data to assign a score, CMS will impute a score of 50.
3. Determine each beneficiaries' payment amount. CMS finalized the per beneficiary payment amounts that correspond to the beneficiary's risk factors-based score as proposed, detailed in Table 53 of the final rule.
4. Calculate the ACO's total quarterly payment amount by summing the per beneficiary payment amounts for each assigned beneficiary, capped at 10,000 beneficiaries. As NAACOS recommended, for ACOs with more than 10,000 assigned beneficiaries, CMS will calculate the total quarterly payment amount based on the 10,000 assigned beneficiaries with the highest risk factors-based scores.

TABLE 53: Quarterly 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 notes that the Part D LIS designation is being incorporated into the risk factors-based score in addition to DES to provide a more standardized measure of low income among the Medicare FFS population, given variability in Medicaid eligibility across different states. Many commenters, including NAACOS, raised major concerns with the use of ADI national percentile ranks as proposed, and offered a variety of alternatives. However, CMS believes that the ADI national percentile rank is the best available option at this time.

Compliance, Monitoring, Termination, and Recoupment

CMS finalized as proposed policies around compliance and monitoring for AIP recipients. CMS will monitor the spending of AIPs to ensure appropriate use by comparing the ACO's spend plan against actual spending. The spend plan does not create a benchmark against which the ACO is held accountable but is intended to increase transparency and allow CMS to track the ACO's progress and any changes to the spend plan. If CMS determines that an ACO has used AIPs for a prohibited expense, CMS may immediately terminate the receipt of AIPs and take compliance action.

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

CMS will recoup AIPs from any shared savings earned by the ACO in any performance year until CMS has recouped all AIPs. This includes performance years in subsequent agreement periods. CMS notes that if an ACO does not earn shared savings in any agreement periods, CMS would not recoup any AIPs. However, CMS would recoup any outstanding balance from a renewing or re-entering ACO that received AIPs in a previous agreement period. CMS also finalized termination policies such that if an ACO terminates its participation agreement during the agreement period in which it received an AIP, the ACO must repay all AIPs received.

Quality

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

Quality Performance Standard and Shared Savings Rates

CMS finalized an alternative quality performance standard that will allow ACOs who fail to meet the prescribed quality performance standard and therefore earn the maximum savings rate, to be eligible to earn a portion of shared savings based on their quality score. Specifically, beginning with PY 2023, if the ACO achieves a quality performance score equivalent to the 10th percentile or higher on at least one of the four outcome measures in the APM Performance Pathway (APP) measure set, the ACO would share in savings at a lower rate that reflects the ACO's final quality performance score. The ACO's final sharing

rate would be a scaled by multiplying the maximum sharing rate for the ACO's track/level by the ACO's quality performance score, which includes any health equity bonus points (described below).

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

Hypothetical Example

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

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

Quality Performance Standard Historic Scores

In the proposed rule, CMS noted it erroneously published weighted (by number of clinicians in the submitting entity) scores for MIPS quality performance category percentile scores for 2018 and 2019 in the 2022 MPFS rule. The corrected historic scores for 2018 and 2019 are significantly lower than previously published and will result in more reasonable quality targets for ACOs. Table 64 in the final rule (reproduced below) shows the corrected historic quality performance category scores and includes the newly published 2021 scores. NAACOS continues to call for more transparency by urging CMS to publish MIPS quality performance category scores annually in Performance Use Files. In the final rule, CMS notes they may consider adding additional information on scoring in future years.

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

Shared Losses and Quality Scores – Enhanced Track Participants

CMS finalized a policy to alter the shared loss rate calculation for Enhanced Track ACOs that do not meet the quality performance standard threshold. Beginning in PY 2023, an ACO that meets the existing quality performance standard or that meets the new alternative quality standard would have shared losses scaled to one minus the product of the maximum sharing rate for the Enhanced Track (75 percent) and the ACO's quality performance score (including any health equity bonus points). The scaled

shared loss rate would be subject to a minimum of 40 percent and a maximum of 75 percent. An ACO that fails to achieve the alternative quality performance score (10th percentile or higher on one outcome measure in the APP set) continues to automatically share in losses at the maximum shared loss rate of 75 percent.

Extending eCQM/MIPS CQM Reporting Incentives

CMS previously finalized incentives for ACOs reporting eCQMs or MIPS CQMs in 2022 or 2023. In this rule, CMS finalizes a policy to extend the availability of the reporting incentive through 2024. To be eligible to achieve maximum shared savings under the current incentive, the ACO reporting eCQMs/MIPS CQMs must achieve (1) a quality performance score of the 10th percentile or higher for at least one of the four outcome measures in the measure set and (2) a quality performance score of the 30th percentile or higher for one of the remaining five measures in the measure set. CMS looks at individual measure benchmarks to determine percentile scores for this calculation; performance benchmarks vary based on the reporting method used.

Health Equity Bonus Points for Qualifying ACOs

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

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

1. Calculate the performance measure scaler. The scaler is calculated for each measure, thus an ACO may fall into a difference performance group for each measure. For the CAHPS measure and claims-based measures, ACOs will be compared to all ACOs performance on those measures, for all other measures performance is evaluated on ACOs reporting eCQMs/MIPS CQMs. The ACO's measure performance scaler is the sum of the scalers for each of the six measures; the maximum total scaler is 24.
    - Top third performing ACOs awarded scaler of 4
    - The middle third performing ACOs awarded scaler of 2
    - The bottom third performing ACOs awarded scaler of zero; ineligible to receive health equity bonus points for this measure
2. Calculate the ACO's underserved multiplier for each ACO. CMS will use the higher value of either:
    - The proportion of an ACO's assigned beneficiary population residing in a census block group with ADI national percentile rank of 85 or higher.
    - The proportion of an ACO's assigned beneficiary population that are dually eligible for Medicare and Medicaid.
    - The proportion of assigned beneficiaries enrolled in the Medicare Part D LIS.

    - If an ACO has less than 20 percent of its population in either category, the ACO is ineligible for the health equity bonus points.
3. Calculate the ACO's health equity bonus points. The ACOs' performance measure scaler (up to 24 points) is multiplied by the ACO's underserved multiplier. The bonus points are capped at 10.
    - For example, an ACO that is a high performer across all six measures (performance scaler of 24) with half of the population served being dual-eligible beneficiaries (underserved multiplier of 0.5) would have health equity bonus points of 12. Therefore, the bonus points would be capped at 10.

The health equity quality bonus points (health equity adjustment) will be available for PY 2023 and subsequent performance years for ACOs reporting eCQMs/MIPS CQMs. CMS will incorporate the health equity adjustment into quality performance reports for MSSP ACOs. CMS will show the calculation of the health equity adjustment, including dual eligibility, LIS and ADI data for all ACOs that report on eCQM/MIPS CQM measures even if the adjustment would not affect the determination of shared savings/losses. CMS plans to share information on these calculations in ACO reconciliation report packages. In addition, CMS also plans to share quarterly and annually, certain beneficiary-identifiable data on dual eligibility, LIS and ADI national percentile rank to enable greater transparency into the calculation of the health equity adjustment.

MSSP Quality Measure Changes

CMS makes no changes to the MSSP quality measure sets for PY 2023. However, CMS does implement a minor change in the name of the All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS measure to Measure 484: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions. Please refer to Table 62 and 63 in the final rule for a list of measures included in the APP measure set for PY 2023. Table 61 in the final rule reviews APP reporting requirements and quality performance standards for PY 2023 and subsequent years. Additionally, CMS finalized several measure specification updates outlined in Table Group C of Appendix 1 in the final rule.

Under MIPS, CMS finalizes a policy to increase the quality data completeness standard from 70 percent to 75 percent in 2024. This data completeness standard also applies to ACOs reporting eCQMs/MIPS CQMs.

Quality Benchmark Changes

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

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

Extreme and Uncontrollable Circumstances Policy

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

MIPS Errors and ACO Financial Determinations

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

Typically, CMS provides MSSP financial reconciliation reports in August of the year following the performance year, with payments to ACOs initiated in September. The timeline for conducting MIPS targeted review may extend past the date CMS issues financial reconciliation reports. Accordingly, CMS may learn of MIPS quality performance calculation errors after MSSP initial financial performance determinations are issued. CMS notes where possible, it would seek to adjust the shared savings payment or shared loss recoupment for the ACO as part of the reconciliation for a subsequent performance year. This approach would not alter the current requirement that ACOs repay shared losses within 90 days after notification of the initial determination of shared losses. NAACOS will closely monitor this process and the impact of MIPS scoring errors on ACO payment determinations and advocate for minimal disruption to ACOs.

Beneficiary Assignment

CMS finalized changes to the MSSP assignment methodology, with new policies taking effect for PY 2023. First, the agency revised the definition of primary care services used to assign beneficiaries to ACOs. CMS added the following newly finalized codes to the MSSP assignment list:

- G0317: prolonged nursing facility services furnished by a physician or non-physician practitioner (NPP) for each additional 15 minutes of time beyond the total time for CPT codes 99306 or 99310, both of which are already included in the MSSP assignment list
- G0318: prolonged home or residence E/M services furnished by a physician or NPP for each additional 15 minutes of time beyond the total time for CPT codes 99345 or 99350, both of which are already included in the MSSP assignment list
- G3002 and G3003: chronic pain management (CPM) services

CMS notes that G0317 and G0318 represent longer time periods for services already included in the definition of primary care services. CMS also reiterates in the final rule that including CPM services is consistent with other care management services currently included in MSSP assignment, given that CPM services are designed to be analogous to Chronic Care Management (CCM) and Principal Care Management (PCM) services (99424 and 99425).

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

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

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

CMS found that an estimated 42,000 additional beneficiaries would have been assigned to MSSP ACOs in PY 2020 if CMS had included newly enrolled CCNs for purposes of assignment. Therefore, beginning with PY 2023, CMS will determine the CCNs enrolled under ACO participant TINs prior to the start of the performance year and periodically during the performance year. CCNs that enroll during the performance year will be reflected in program operations including assignment, revenue and expenditure calculations, and financial reconciliation. CMS will include all CCNs with active or deactivated enrollment status in determining assignment for the applicable performance year. This applies to CCNs that are deactivated but later reactivated, or that are disenrolled as one facility type but later re-enrolled as another type of ACO provider/supplier. CMS will continue its current process to not allow CCNs to switch between ACOs during the performance year. Importantly, these policies only apply 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 for the purposes of program operations on a periodic basis throughout the performance year.

Administrative Burden Reduction

Marketing Material Requirements

CMS currently requires that any marketing materials and activities used by an ACO, and its participants or providers/suppliers must be submitted to CMS prior to use. If the ACO certifies compliance with all marketing requirements and CMS approves the marketing materials or activities, they may be used five business days following submission. Citing the operational burden imposed on and the time and resources expended by CMS to review submitted marketing materials, CMS has finalized its proposal to remove the requirement that ACOs must submit marketing materials to CMS before. Instead, CMS will require that ACOs provide marketing materials and activities only upon request.

Beneficiary Notification Requirements

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

- Clarified that beneficiary notification signs must be posted in all ACO participant facilities, regardless of whether primary care services are provided in each facility.
- Reduced the frequency of the annual standardized written notices from once per performance year to once per five-year agreement period. The standardized written notice must be furnished prior to or at the first primary care service visit during the first performance year in which the beneficiary receives a primary care service from an ACO participant.
- Established a new follow-up communication requirement in conjunction with the standard beneficiary notice. The communication may be written or verbal communication and must occur no later than the beneficiary's next primary care service visit or 180 days after the standardized written notice was provided. CMS clarified in the final rule that the follow-up may be furnished via email or patient portal. ACOs will be required to track and document how the follow-up communication is implemented and make this documentation to CMS upon request. The requirement provides flexibility in how the follow-up is implemented so long as it includes a meaningful opportunity for beneficiaries to ask questions and engage with a representative of the ACO or ACO participant. CMS believes this will reduce beneficiary confusion and improve beneficiary comprehension.

NAACOS strongly urged CMS not to implement the follow-up communication requirement, as it will create significant operational burden for ACOs and may cause additional beneficiary confusion. CMS contends that the flexibility provided in the policy in addition to the reduced frequency of the standard beneficiary notification will lead to an overall reduction in burden. In the final rule, CMS states that the agency is working to revise both the standard beneficiary notification and poster template language, which will be made available this fall for use beginning at the start of PY 2023.

Streamline SNF Three-Day Rule Waiver Application Review Process

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

Recognize ACOs Structured as OHCAs for Data Sharing Purposes

While most ACOs function as business associates of their covered entity ACO participants, some ACOs may choose to operate as organized health care arrangements (OHCAs), another type of entity that is recognized under HIPAA under the authority of the HHS Office for Civil Rights (OCR) and the Office of the

National Coordinator for Health Information Technology (ONC). ACOs that operates as OHCAs can share protected health information (PHI) among the covered entities in the OHCA. Accordingly, CMS is finalizing their proposal to modify the MSSP data sharing regulations to specify that ACOs acting as OHCAs may request aggregate reports and beneficiary identifiable claims data from CMS. CMS states its intention to update the data sharing regulations to reflect how ACOs may be structured and provide flexibility with respect to the different arrangements permitted under the Health Insurance Portability and Accountability Act (HIPAA) for purposes of data sharing.

PHYSICIAN PAYMENT AND POLICY CHANGES

Payment Update

CMS finalized a CY 2023 Medicare conversion factor (CF) of $33.06, a decrease of $1.55, or about 4.5 percent, from the 2022 CF rate of $34.61. The update reflects the statutorily required 0 percent update for CY 2023, the expiration of the temporary 3 percent increase in payment provided by the Protecting Medicare and American Farmers from Sequester Cuts Act and a statutorily required -1.5 percent budget neutrality adjustment.

E/M Visits

In recent years, CMS has overhauled E/M visits, updating coding and payment to better reflect the current practice of medicine and reduce administrative complexity. Generally, CMS has adopted revisions by the American Medical Association Current Procedural (AMA CPT) Editorial Panel to base E/M visits on time spent and medical decision-making (MDM). In the CY 2023 final rule, CMS finalized updates to "Other E/M visits," which include inpatient and observation visits, emergency department visits, nursing facility visits, domiciliary or rest home visits, home visits, and cognitive impairment assessment. Additionally, CMS finalized new prolonged services codes for inpatient/observation visits, nursing facility visits, and home or resident visits. Table 24 in the final rule provides details on these codes.

Behavioral Health

CMS finalized a number of new behavioral health provisions aimed at advancing the agency's 2022 Behavioral Health Strategy to address the national mental health crisis. In this final rule, CMS:

- Created new payments for chronic pain management and treatment bundles; Healthcare Common Procedure Coding System (HCPCS) codes G3002 (CPM monthly bundle) and G3003 (add-on code for each additional 15 minutes of CPM services).
- Amended direct supervision requirement under "incident to" regulation to allow behavioral health services to be furnished by auxiliary personnel under the general supervision of a physician or NPP.
- Created a new G-code (G0323) for general behavioral health integration (GBHI) performed by clinical psychologists or clinician social workers who are not authorized to bill under the current E/M code for GBHI services.
- Increased payment rates to opioid treatment programs and expanded telehealth access for medication assisted treatments.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS finalized changes to allow RHCs and FQHCs to furnish new care management services for CPM and GBHI, as described above. CMS will include CPM services in the general care management HCPCS code G0511. Additionally, CMS clarified that when clinical psychologists and clinical social workers provide services described in G0323 in an RHC or FQHC, they can bill G0511. CMS also finalized conforming regulatory text changes to implement telehealth provisions of the CAA (2021 and 2022), extending payment for telehealth services furnished by RHCs and FQHCs and delaying the in-person requirements for tele-mental health visits furnished by RHCs and FQHCs through the 151-day period following the end of the COVID-19 PHE.

Telehealth and Other Services Involving Communications Technology

Covered Telehealth Services

CMS finalized adding more than 50 codes to the Medicare Telehealth Services List temporarily through the end of 2023. The full list of these services can be found on Table 12 of the final rule. CMS created this temporarily covered list, Category 3 services, during the COVID-19 PHE to give regulators more time to study whether services can be permanently added to the Medicare's telehealth list at a later date. CMS did not finalize its proposal to keep telephone E/M services on the Medicare Telehealth Services List after the end of the PHE and the 151-day post-PHE extension period.

CMS finalized that it will continue to pay for telehealth services at the place of service that would have been paid if the service was furnished in-person. This policy through the end of 2023 or the calendar year in which the PHE ends.

PHE-Related Flexibilities

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

Remote Monitoring

CMS withdrew its proposal to create four new HCPCS G-codes for remote therapeutic monitoring (RTM) services (GRTM1- GRTM4). The codes were intended to increase patient access and reduce supervisory burden by allowing "incident" to billing by auxiliary staff under general supervision. Instead, CMS clarified in the final rule that all existing RTM codes may be delivered under general supervision.

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

QUALITY PAYMENT PROGRAM

Merit Based Incentive Payment System (MIPS) Policies

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

MIPS Payment Adjustments

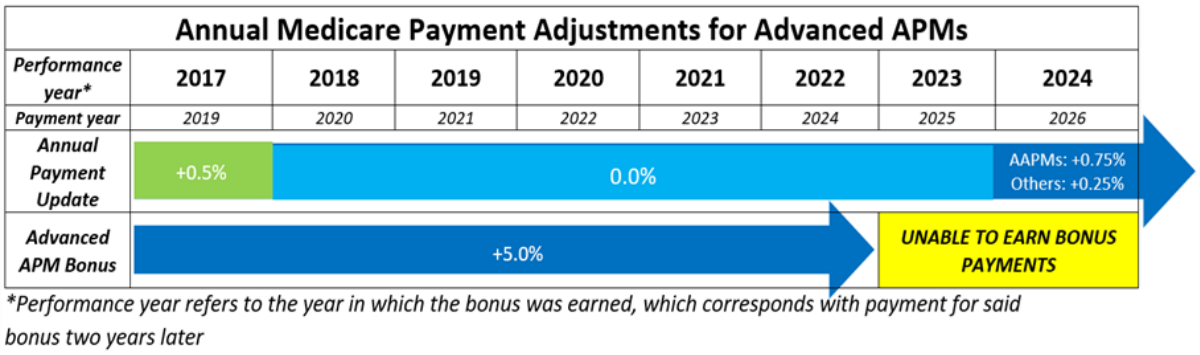
CMS finalizes a policy to maintain a 75-point performance threshold for PY 2023, which corresponds to 2025 payments. As a reminder, there is no exceptional performance bonus for PY 2023 (2025 payments) and beyond. Figure 4 in the final rule provides an illustrative example of MIPS payment adjustment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

Promoting Interoperability

CMS finalizes several changes to the Promoting Interoperability performance category scoring as well as measure requirements and certification criteria for 2023, outlined in Table 95.

Advanced Alternative Payment Models (APMs)

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



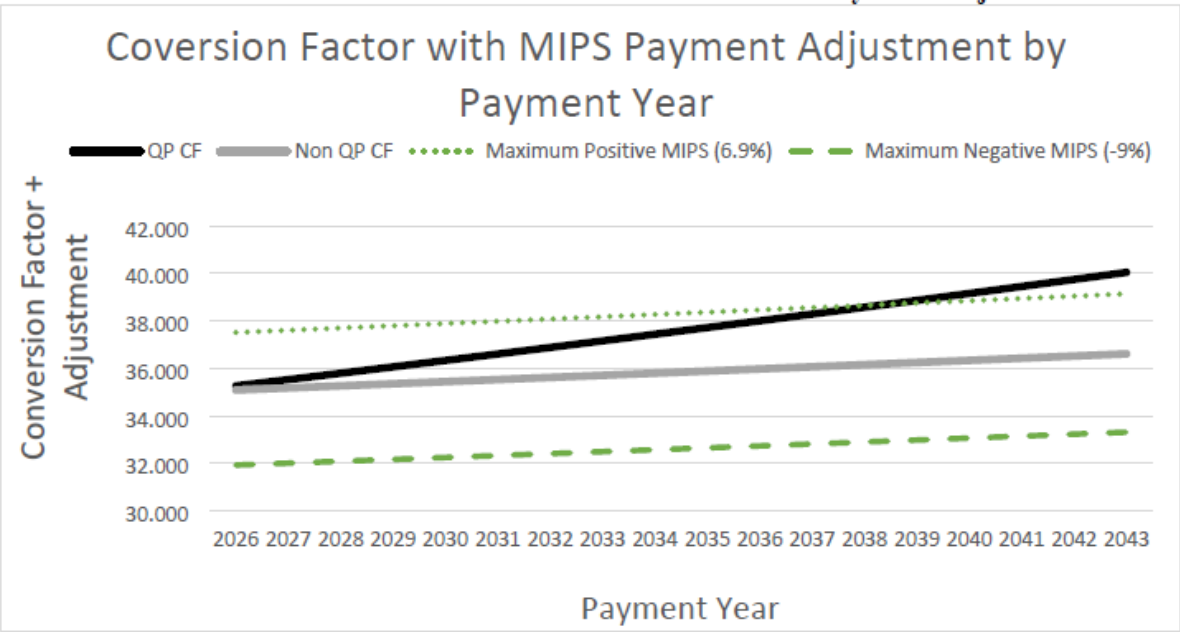
NAACOS is strongly advocating for Congress to extend the Advanced APM incentive payment and give CMS the authority to set QP thresholds. These actions must be taken by Congress. NAACOS has been working with lawmakers to build support for an extension.

CMS finalized several modifications to the Advanced APM regulations:

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

In the rule, CMS expresses concern that the substantial difference between the QP conversion factor and maximum positive payment adjustment available under MIPS might affect the willingness of eligible clinicians to participate in Advanced APMs for several years to come. CMS also projects that increasing QP thresholds will result in nearly 100,000 fewer QPs in 2023. CMS projects that there will be between 144,700 and 186,000 QPs during PY 2023, which is a significant drop from the 225,000 to 290,000 estimated QPs for PY 2022. This could also impact the availability and distribution of funds in the budget neutral MIPS payment pool because many Advanced APM would likely be high performers under MIPS. As illustrated in Figure 5 (reproduced below), the QP conversion factor that will be compounded annually is not expected to catch up to maximum MIPS bonuses until after CY 2035. The agency also issued a request for information in the proposed rule to learn more from stakeholders about their plans to continue participating in Advanced APMs going forward. The proposed rule also asked for public comment on the idea of transitioning away from an APM entity level QP determination and instead making QP determinations at the individual eligible clinician level for all eligible clinicians in Advanced APMs.

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.