Physician Fee Schedule Proposed Rule for 2023
Summary Part II

Medicare and Medicaid Program: 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts
[CMS-1770-P]

On July 7, 2022, the Centers for Medicare & Medicaid Services (CMS) placed on public display a proposed rule relating to the Medicare physician fee schedule (PFS) for CY 2023[1] and other revisions to Medicare Part B policies. The proposed rule is scheduled to be published in the July 29, 2022 issue of the *Federal Register*. If finalized, policies in the proposed rule generally would take effect on January 1, 2023. **The 60-day comment period ends at close of business on September 6, 2022.**

HFMA is providing a summary in three parts. Part I covers sections I through III.N (except for Section G: Medicare Shared Savings Program Requirements) and the Regulatory Impact Analysis. Part II will cover the Medicare Shared Savings Program Requirements. Part III will cover the updates to the Quality Payment Program.

Part II includes proposals related to the Medicare Shared Savings Program. These are designed to strengthen financial incentives for long-term participation by modifying the benchmarking methodology, expanding opportunities for certain low revenue ACOs and those serving high risk and dual eligible populations. It also aims to make operational improvements to reduce administrative burden and makes numerous revisions to the quality reporting and the quality performance requirements.

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[1] Henceforth in this document, a year is a calendar year unless otherwise indicated.

1. Executive Summary

Under the Shared Savings Program, providers and suppliers that participate in an Accountable Care Organization (ACO) continue to receive traditional Medicare FFS payments under Parts A and B, and the ACO may be eligible to receive a shared savings payment if it meets specified quality and savings requirements—and in some instances may be required to share in losses if it increases health care spending.[2] CMS reviews in detail the legislative and regulatory history of the Shared Savings Program.[3] with updates regarding the number of participating providers and beneficiaries. As of January 1, 2022, over 11 million people with Medicare receive care from one of the 528,966 health care providers in the 483 ACOs participating in the Shared Savings Program.

CMS says policies in this proposed rule are intended to reverse the following recent trends in the Shared Savings Program and to **advance equity** (CMS' emphasis):

- In recent years, growth in the number of beneficiaries assigned to ACOs has plateaued.
- Higher-spending populations are increasingly underrepresented in the program since the change to regionally adjusted benchmarks.
- Access to ACOs appears inequitable as shown by data indicating that Black (or African American), Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native beneficiaries are less likely to be assigned to an ACO than their Non-Hispanic White counterparts.

CMS cites feedback from health care providers treating underserved populations—that they require upfront capital to make the necessary investments to succeed in accountable care and may also need additional time under a one-sided model before transitioning to performance-based risk (also known as a two-sided model). Thus, CMS proposes to provide advance shared savings payments to low revenue ACOs that are inexperienced with performance-based risk Medicare ACO initiatives, that are new to the Shared Savings Program, and that serve underserved populations. These advance investment payments (AIPs) would increase when more beneficiaries who are dually eligible for Medicare and Medicaid or who live in areas with high deprivation (measured by the area deprivation index (ADI)),[4] or both, are assigned to the ACO. These funds—a one-time fixed payment of $250,000 and quarterly payments for the first 2 years of an ACO's 5-year agreement period, remaining available for use over the 5-year period—would be available to address the social needs of people with Medicare, as well as health care provider staffing and infrastructure. CMS says additional proposed modifications would support organizations new to accountable care by providing greater flexibility in the progression to performance-based risk, allowing these organizations more time to redesign their care processes to be successful under risk arrangements.

[2] In this section of the summary, all references to ACOs are to ACOs participating in the Shared Savings Program.
[3] Section 1899 of the Act contains statutory provisions of the Shared Savings Program, with regulations codified at 42 CFR part 425.
[4] The preamble of the proposed rule describes the background of the ADI measure and how it is calculated. The ADI data files are publicly available for download at https://www.neighborhoodatlas.medicine.wisc.edu/.

CMS is also proposing a health equity adjustment that would upwardly adjust ACOs' quality performance scores to continue encouraging high ACO quality performance, transition ACOs to all-payer electronic clinical quality measures (eCQMs) and Merit-based Incentive Payment System clinical quality measures (MIPS CQMs), and support those ACOs serving a high proportion of underserved beneficiaries while also encouraging all ACOs to treat underserved populations. Finally, CMS is proposing certain changes to the benchmarking methodologies to encourage participation by health care providers who care for populations that include a high percentage of beneficiaries with high clinical risk factors and beneficiaries dually eligible for Medicare and Medicaid.

In this proposed rule, CMS says it is accomplishing the following:

- Strengthening financial incentives for long term participation by reducing the impact of ACOs' performance on their benchmarks;
- Addressing the impact of ACO market penetration on regional expenditures used to adjust and update benchmarks;
- Supporting the business case for ACOs serving high risk and dually eligible populations to participate;
- Modifying the benchmarking methodology to mitigate bias in regional expenditure calculations that benefits ACOs electing prospective assignment;
- Expanding opportunities for certain low revenue ACOs participating in the BASIC track (one-sided shared savings-only model) to share in savings even if they do not meet the minimum savings rate (MSR), to allow for investments in care redesign and quality improvement activities among less capitalized ACOs;
- Eliminating the requirement for an ACO to submit marketing materials to CMS for review and approval prior to disseminating materials to beneficiaries and ACO participants (but still requiring submission of marketing materials to CMS upon request);
- Streamlining the SNF 3-day rule waiver application review process;
- Reducing the frequency with which beneficiary information notices are provided to beneficiaries (from annually to a minimum of once per agreement period, with a proposed follow-up beneficiary communication serving to promote beneficiary comprehension of the standardized written notice);
- Revising data-sharing requirements to recognize ACOs structured as organized health care arrangements (OHCAs) for data sharing purposes; and
- Making numerous revisions to the quality reporting and the quality performance requirements for performance year 2023 and subsequent performance years.

CMS anticipates that the Shared Savings Program proposals will increase participation, particularly from ACOs serving beneficiaries with greater needs and higher baseline spending. The incentive for ACOs to reduce spending over multiple agreement periods is also expected to be bolstered—for example, by reducing the weighting on the regional component of the benchmark update and by providing a prior savings adjustment at rebasing.

CMS projects a $15.5 billion decrease in spending on benefits (that is, savings from efficiency) and $650 million in higher net shared savings payments to ACOs, resulting in $14.8 billion lower overall spending compared to the program baseline.

To make these changes, CMS cites the authority granted in section 1899(i)(3) of the Act to use other payment models that the Secretary determines will improve the quality and efficiency of items and services furnished under the Medicare program, and that do not result in program expenditures greater than those that would result under the statutory payment model. Specifically, CMS lists the following proposals as requiring use of 1899(i) authority:

- Allowing for AIPs;
- Modifying the calculation of the shared loss rate under the ENHANCED track to allow for a sliding scale based on an alternative quality performance standard;
- Incorporating a prospectively projected administrative growth factor—a variant of the United States Per Capita Cost (USPCC), referred to in this proposed rule as the Accountable Care Prospective Trend (ACPT)—into a three-way blend with national and regional growth rates to update an ACO's historical benchmark and address increasing market saturation by ACOs in a regional service area;
- Expanding the criteria for certain low revenue ACOs participating in the BASIC track to qualify for shared savings in the event the ACO does not meet the MSR as required under section 1899(d)(1)(B)(i) of the Act; and
- Excluding the proposed new supplemental payment for Indian Health Service (IHS)/Tribal hospitals and Puerto Rico hospitals from the determination of Medicare Parts A and B expenditures used in certain financial calculations under the Shared Savings Program.

These provisions are summarized in greater detail below.

2. Shared Savings Program Participation Options

a. Increasing Participation in Accountable Care Models in Underserved Communities by Providing an Option for Advance Investment Payments to Certain ACOs

CMS lays out the rationale for the new AIPs by describing a need for start-up ACO investment, relying on the experience of prior models that provided such funding. CMS acknowledges that the start-up investment costs for an ACO can be substantial, particularly for a small organization or an organization caring for underserved or more medically complex patients. The CMS Innovation Center previously tested two models to assess whether such up-front payments would increase participation in the Shared Savings Program by ACOs serving rural or underserved regions—the Advance Payment (AP) ACO Model, which operated from 2012 to 2015, and the ACO Investment Model (AIM), which operated from 2015 to 2018. Both models operated by prepaying shared savings to ACOs and later recouping those amounts from earned shared savings (if any).

AP ACOs received between $1.3 million and $2.7 million in prepaid shared savings, via an up-front payment of $250,000 per ACO plus $36 per beneficiary, followed by an $8 per beneficiary per month payment for 2 years. In AIM, the prepaid shared savings amounts were distributed and recouped in the same amounts and manner as the AP ACO model for the majority of model participants. The AP Model did not significantly improve the quality or cost of care. However,

AIM successfully encouraged ACOs to form in areas where ACOs may not have otherwise formed and where other Medicare payment and delivery innovations were less likely to be present. AIM generated an estimated net aggregate reduction in spending by Medicare of $381.5 million after accounting for Medicare's payment of AIM funds and ACOs' earned shared savings, without reducing the quality of care provided to beneficiaries. CMS acknowledged continued interest in the AIM and AP ACO models and approaches with similar up-front and ongoing payments for ACOs newly participating in the Shared Savings Program.

Consequently, CMS proposes to make advance shared savings payments—referred to as advance investment payments (AIPs)—to certain ACOs participating in the Shared Savings Program, to improve the quality and efficiency of items and services furnished to Medicare beneficiaries. Such payments would be made in accordance to standards proposed in a new 42 CFR §425.630.

CMS envisions that this new payment option would distribute AIPs to ACOs for 2 years in order to reduce the financial barriers encountered by small providers and suppliers as they join the Shared Savings Program. These payments would be recouped from shared savings the ACO earned, if any.

AIP Eligibility. CMS proposes to limit eligibility for AIP funding to new ACOs and ACOs inexperienced with performance-based risk Medicare ACO initiatives. AIP eligibility builds on AIM, but with more inclusive eligibility criteria that CMS considers necessary to scale advance payments from a model to a regular component of the Shared Savings Program and to align with the Innovation Center's stated vision for health care transformation. CMS is also broadening the eligibility criteria compared to AIM to reflect its belief that it is important to provide an incentive for providers and suppliers who serve high need beneficiaries in all areas to form ACOs, including underserved beneficiaries who reside in urban areas. Therefore, CMS does not limit the opportunity for an ACO to receive AIPs to ACOs in only rural communities or in areas with low ACO penetration.

Specifically, in proposed §425.630(b), an ACO would need to meet all of the following criteria to be eligible for AIPs:

- Not a renewing ACO or re-entering ACO;
- Has applied to participate in the Shared Savings Program under any level of the BASIC track glide path (because this participation option is indicative of an ACO's inexperience with performance-based risk, in which ACOs are typically less experienced with risk and are more likely to benefit from up-front funding or ongoing financial assistance);
- Eligible to participate in the Shared Savings Program;
- Inexperienced with performance-based risk Medicare ACO initiatives; and
- A low revenue ACO (defined in current §425.20 as having less than 35 percent of its Medicare A and B fee-for-service revenue through assigned beneficiaries based on the most recent calendar year for which 12 months of data are available).

CMS seeks comments on these proposals.

AIP Application Procedure. The initial application cycle to apply for AIPs would be for a January 1, 2024, start date. In the new §425.630(c), CMS proposes to codify the application

process for AIPs. In order to obtain a determination regarding whether an ACO may receive AIPs, it must submit, as part of its application to participate in the Shared Savings Program, complete supplemental application information in the form and manner and by a deadline specified by CMS.

The application cycle for AIPs would be conducted as part of and in conjunction with the Shared Savings Program application process, with instructions and timelines published through the Shared Savings Program website. As previously mentioned, ACOs currently participating in the Shared Savings Program or applying to renew their participation agreement would not be eligible to apply. CMS intends to provide further information regarding the process, including the application and specific requirements such as the deadline for submitting applications, through subregulatory guidance and will also provide a feedback process to afford an opportunity for the applicant to clarify or revise its application.

AIP application contents. As proposed in the new §425.630(d), an ACO would be required to submit a spend plan as part of its application for AIPs. The spend plan must:

- Identify how the ACO will spend the AIPs during the agreement period to build care coordination capabilities (including coordination with community-based organizations, as appropriate),
- Address specific health disparities,
- Meet other criteria under §425.630,
- Identify the categories of goods and services that will be purchased with AIPs, the dollar amounts to be spent on the various categories, and such other information as may be specified by CMS, and
- State that the ACO will establish a separate designated account for the deposit and expenditure of all AIPs.

CMS says it does not intend for the proposed spend plan to create a benchmark requirement against which it would hold the ACO accountable, but rather it is intended to aid CMS in tracking ACO progress toward implementing their spend plan and any challenges or changes in strategy that occur following their receipt of AIPs.

Use and Management of AIPs. Although current regulations do not require an ACO to spend its shared savings in any particular way, CMS proposes to specify how an ACO may use AIPs, citing three reasons:

- The purpose of AIPs,
- The fact that AIPs are made before any shared savings are actually earned by an ACO, and
- CMS' proposed limitations on the recovery of AIPs in the absence of earned shared savings.

Thus, an ACO must use AIPs to improve the quality and efficiency of items and services furnished to beneficiaries by investing in the following categories:

- Increased staffing,
- Health care infrastructure, and

- The provision of accountable care for underserved beneficiaries, which may include addressing social determinants of health (SDOH).

CMS offers numerous examples of permitted uses within these three categories, while emphasizing that AIP amounts are advance shared savings and are not payment or reimbursement for items or services under the three specified categories. **CMS solicits comment on whether there are additional categories of expenses that should be permitted in light of the purposes of AIPs.**

In the preamble, CMS also provides examples of prohibited uses of AIPs, including management company or parent company profit, performance bonuses, other provider salary augmentation, provision of medical services covered by Medicare, or items or activities unrelated to ACO operations that improve the quality and efficiency of items and services furnished to beneficiaries. However, performance bonuses could be tied to successful implementation of SDOH screenings or care management guidelines, or ACOs could pay a higher salary as necessary to retain a clinician who treats underserved beneficiaries. The proposed regulation specifically prohibits AIPs from being used for any expense other than an allowable use or to repay shared losses of ACOs in Level E of the BASIC track. **CMS solicits comment on these examples of prohibited uses and whether there are additional categories of expenses that should be prohibited in light of the purposes of AIPs.**

To allow CMS to monitor whether the funds are used only for allowable uses and to ensure that AIPs do not pay for any prohibited uses, CMS proposes to require ACOs to segregate AIPs from all other revenues by establishing and maintaining a separate account into which the ACO must immediately deposit all AIPs and from which all disbursements of such funds are made only for allowable uses. Although CMS would deposit AIPs into the same account used for the deposit of shared savings payments, upon receipt of AIPs, the ACO must immediately deposit the funds into the separate AIP account.

AIP Methodology. During the first 2 performance years of the ACO's participation agreement, AIPs would include a one-time fixed payment of $250,000 and 8 quarterly payments based on the number of assigned beneficiaries (capped at 10,000 beneficiaries for AIP payment-calculation purposes). CMS believes that initial ACO start-up costs do not vary significantly by the size of an ACO or by the underlying level of risk of an assigned beneficiary population. However, **CMS seeks comment on the proposal to provide eligible ACOs with a one-time payment of $250,000, as well as alternatives such as allowing the one-time payment to vary based on the number of assigned beneficiaries, the risk factors of the ACO's assigned beneficiary population, or both.**

As with the one-time payment, the structure of the quarterly payments is informed by CMS' experience in AIM, where ACO participants had variable costs for clinical care management activities (such as clinical staff) supported by the per beneficiary per month payments. CMS considered monthly and additional annual payments. However, monthly payments would result in additional operation burden for CMS that is not feasible and offers little additional benefit to ACOs relative to quarterly payments, according to CMS. On the other hand, CMS believes the

benefit to ACOs of consistent payments on a quarterly basis—compared to additional annual amounts—outweighs the administrative costs of calculating quarterly payments. **CMS seeks comment on the proposed schedule of the AIPs to ACOs.**

The ACO's upcoming quarterly payment amount would be determined prior to the start of each quarter based on the latest available assignment list for the performance year. (An alternative under consideration by CMS is based on the beneficiaries assigned to the ACO at the beginning of a performance year, which could remain fixed for the duration of that performance year. This would provide certainty regarding the amount of payments over the course of the year, but carries the risk that CMS would underpay or overpay relative to the quarterly determination. **CMS seeks comment on this alternative proposal for the quarterly payment determination.**)

The 8 quarterly AIPs would be based on the number of assigned beneficiaries (capped at 10,000), adjusted by a risk factors-based score for each beneficiary, taking into account dual-eligibility status and the ADI national percentile ranking of the census block group of the beneficiary's primary address. Specifically, CMS would complete the following steps to calculate the ACO's quarterly AIP amount:

- Step 1: Determine the ACO's assigned beneficiary population.
- Step 2: Assign each beneficiary a risk factors-based score, as follows:
    - 100 (producing maximum payment amount) if the beneficiary is dually eligible for Medicare and Medicaid—which corresponds to a quarterly payment of $45.
    - If the beneficiary is not dually eligible, assign a risk factors-based score equal to the ADI national percentile rank of the census block group corresponding with the beneficiary's primary mailing address.
    - 50 if the beneficiary is not dually eligible and cannot be matched with an ADI national percentile rank due to insufficient data—which corresponds to a quarterly payment of $28.
- Step 3: Determine the payment amount for each beneficiary, based on the risk factors-based score, shown below from Table 42 and proposed §425.630(f)(2)(iii).

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

- Step 4: Calculate the ACO's total quarterly payment amount. If the ACO has more than 10,000 assigned beneficiaries, CMS would calculate the quarterly payment amount based on the 10,000 assigned beneficiaries with the highest risk factors-based scores.

CMS offered various alternatives for the calculation of the quarterly AIPs, for which it seeks comments.

AIP Compliance and Monitoring. CMS proposes to monitor the spending of AIPs to provide CMS with a clear indication of how ACOs intend to spend AIPs, provide adequate protection to the Medicare Trust Funds, and to prevent funds from being misdirected or appropriated for

activities that do not constitute a permitted use of the funds. CMS would compare the anticipated spending in the spend plan to the actual spending reported on the ACO's public reporting webpage, including any expenditures not identified in the spend plan. The reported annual spending must include any expenditures of AIPs on items not identified in the spend plan. ACOs would be required to annually report their actual expenditures via an updated spend plan on their public reporting webpage.

If CMS determines that an ACO had disbursed AIPs for a prohibited use, CMS could take compliance action in existing §§425.216 and 425.218 and could terminate the ACO's receipt of AIPs. Any AIPs that are unspent at the end of the ACO's agreement period must be repaid to CMS.

CMS is concerned about the possibility that an ACO may be eligible to receive AIPs and then quickly thereafter seek to add ACO participants experienced with performance-based risk, thereby avoiding the inexperience and low-revenue eligibility requirements. Therefore, CMS proposes to monitor ACOs that receive AIPs for changes in the risk experience of ACO participants that would cause an ACO to be considered experienced with performance-based risk or a high revenue ACO and therefore ineligible for AIPs. As proposed, the ACO would be obligated to repay spent and unspent AIPs if CMS takes pre-termination action under §425.216 and the ACO continues to be experienced with performance-based risk Medicare ACO initiatives or a high revenue ACO after a deadline specified by CMS pursuant to such compliance action (for example, the next deadline for updating the ACO participant list). To retain its AIP, an ACO that CMS determines to be experienced with performance-based risk or a high revenue ACO would be required to remedy the issue by the deadline specified by CMS. For example, if the ACO participants' total Medicare Parts A and B FFS revenue has increased in relation to total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries, the ACO could remove an ACO participant from its ACO participant list so that the ACO could meet the definition of a low revenue ACO.

Although CMS' existing pre-termination actions for ACOs do not include the cessation of payments to an ACO, CMS proposes at §425.630(h) that it may immediately terminate an ACO's receipt of AIPs if the ACO does any of the following:

- Ceases to meet the eligibility requirements,
- Fails to comply with other AIP requirements, or
- Meets any of the grounds for termination set forth generally for ACOs at §425.218(b).

Recoupment. In AIM, CMS recouped prepaid shared savings from any shared savings earned by an ACO in its current agreement period, and if necessary, future agreement periods. If the ACO did not achieve shared savings, then the prepaid shared savings were not recouped. Additionally, the balance of funding was not recouped if the ACO completed the agreement period and decided not to reenroll in a second agreement period. However, if the ACO terminated prior to the end of its 3-year agreement period, the remaining balance was required to be repaid in full. During AIM, CMS observed that offering new small ACOs prepaid shared savings that they were not at risk of being forced to repay if they did not achieve savings was a critical incentive for small providers and suppliers to form ACOs to join AIM. This experience

in AIM informs CMS' proposal at §425.630(g) for recoupment of the AIPs from an ACO in the Shared Savings Program, which now has 5-year agreement periods.

Regarding recoupment of AIPs, CMS proposes the following:

- AIPs are recouped from any shared savings earned by the ACO in any performance year until CMS has recouped all AIPs.
- If there are insufficient shared savings to recoup the AIPs in a performance year, that remaining balance would be carried over to the subsequent performance year(s) in which the ACO achieves shared savings, including any performance year(s) in a subsequent agreement period.
- CMS will not recover an amount of AIPs greater than the shared savings earned by an ACO in that performance year. Thus, if an ACO does not earn shared savings, none of the AIPs would be recouped from the ACO.
- If an ACO terminates its participation agreement during the agreement period in which it received an AIP, the ACO must repay all AIPs it received.
- The proposed regulation also contains details in the event of bankruptcy.

CMS seeks comment on all aspects of the proposals for recoupment of the AIPs made to ACOs.

b. Smoothing the Transition to Performance-Based Risk in ACOs

Background. CMS notes that the Shared Savings Program, since its inception in 2012, has included both one-sided financial models (also known as shared savings only, or upside only) and two-sided financial models (shared savings and shared losses, or upside and downside risk) for ACOs to select based on the arrangement that makes the most sense for their organization. Over the years, CMS has modified available financial models (participation options) providing "on-ramps" to attract both those that are new to value-based purchasing, as well as more experienced entities that are ready to accept two-sided risk. CMS has modified these participation options to adjust the maximum level of risk that must be assumed under two-sided models and to smooth the transition to two-sided models. In the preamble, CMS walks through the history of these modifications in the Shared Savings Program.

Most recently (December 2018 final rule at 83 FR 67822), CMS redesigned the participation options to transition more rapidly to two-sided models under two tracks—a BASIC track and an ENHANCED track. Both tracks are designed for 5-year agreement periods. The BASIC track includes a glide path with 5 Levels (A through E) that allows eligible ACOs to begin under a one-sided model for 2 years (each year of which is identified as a separate level (Levels A and B)) and advance to a two-sided model that includes incrementally higher levels of risk and reward (Levels C, D, and E) for the remaining 3 years of the agreement period. CMS allowed additional flexibility for new ACOs that qualify as low revenue ACOs inexperienced with performance-based risk Medicare ACO initiatives[5] to participate for up to 3 performance years under a one-sided model (4 performance years in the case of ACOs entering an agreement period

[5] Current regulations at §425.20 define "experienced with performance-based risk Medicare ACO initiatives" and "inexperienced with performance-based risk Medicare ACO initiatives."

beginning on July 1, 2019) of the BASIC track's glide path before transitioning to the highest level of risk and potential reward under the BASIC track (Level E) for the final 2 years of the agreement period. Based on a combination of factors, CMS determines an ACO's eligibility for participation options in the BASIC track and ENHANCED track, along with the number of agreement periods that the ACO may participate in the BASIC track.

An ACO's ability to participate in the BASIC track is limited, and all ACOs eventually must transition to participation in the ENHANCED track to continue in the program. High revenue ACOs are limited to, at most, a single agreement period under the BASIC track prior to transitioning to participation under the ENHANCED track. Low revenue ACOs are generally limited to 2 agreement periods—for a total of 10 performance years—under the BASIC track. Current regulations require that should a low revenue ACO identified as experienced with performance-based risk Medicare ACO initiatives have changes in the revenue of its ACO participants that would cause the ACO to be considered a high revenue ACO (as these terms are defined in §425.20), the ACO must take corrective action or terminate its participation under the BASIC track by the end of the current performance year.

Many comments to the December 2018 final rule disagreed with the more aggressive transition of ACOs to performance-based risk. Some also noted that while this may increase ACO performance of those that continue to participate, it could reduce participation overall. CMS observed this with AIM participants, which meaningfully outperformed peer ACOs but then dropped out at an elevated frequency before even attempting to enter the one-sided model (upside-only) portion of the BASIC track glide path. CMS believes this suggests two things:

- While an upside-only participation option with a lower shared savings rate can be a highly effective incentive for smaller, low-revenue ACOs targeted by AIM, such ACOs also likely feel a correspondingly magnified disincentive to accept exposure to even the limited downside risk presented by the current BASIC track glide path.
- Not even superior performance under Track 1 appears to provide enough confidence for such ACOs to consistently move into participation options leading to assumption of two-sided risk.

In response to several commenters' concerns that requiring the rapid assumption of significant levels of risk by ACOs would discourage new participants and impede current ACOs' ability to make patient-centered infrastructure investments that are necessary for successful participation, CMS had stated its commitment to continue to monitor program participation and consider further refinements to the program's participation options. Most commenters on the participation options that were finalized in December 2018 recommended that CMS extend the time an ACO can participate in a one-sided model to 3 performance years, as opposed to the 2 performance years adopted generally under the BASIC track.

Table 43, reproduced below, shows that 59 percent of the 483 ACOs are in a two-sided model.

TABLE 43: 2022 Shared Savings Program ACO Track Information

ACO Track	ACOs	Percent
One Sided (41% of ACOs)		
BASIC Track Levels A&B	199	41%
Two Sided (59% of ACOs)		
BASIC Track Levels C&D	40	8%
BASIC Track Level E*	98	21%
ENHANCED Track*	146	30%
TOTAL ACOs PY 2022	483	100%

*Qualifies as an Advanced Alternative Payment Model (APM).
Note: Tracks 1, 2, 3 and the Track 1+ ACO Model are no longer applicable as of PY 2022.

In 2020 and 2021, due to the PHE for COVID-19, CMS provided additional participation option flexibilities, allowing ACOs participating in the BASIC track's glide path the option to elect to forgo automatic advancement and "freeze" their participation for PY 2021 and PY 2022 at their PY 2020 and 2021 levels, respectively. CMS reports that 140 out of 157 (89 percent) currently participating ACOs chose to maintain their participation in a one-sided model rather than move to risk for PY 2021, and 103 out of 140 (74 percent) for PY 2022.

CMS believes it would be prudent to provide greater flexibility for ACOs to join the program under one-sided risk and to remain in the program under lower levels of performance-based risk in order to balance CMS' desire to see more ACOs participate under performance-based risk while also working toward the goal of increasing overall Shared Savings Program participation and improving outcomes for beneficiaries. CMS believes it would be appropriate to allow certain ACOs in their first agreement period in the program to maintain participation in a one-sided model (with a lower sharing rate) for a longer period of time, rather than risk having those ACOs leave the program altogether to avoid transitioning to two-sided risk. Even if an ACO does not earn shared savings, ACOs have demonstrated that they are likely saving Trust Fund dollars by modifying their ACO participants' behavior to coordinate care and carry out other interventions to improve quality and financial performance.

CMS is also concerned that the current policy of considering an ACO's status as a high- or low-revenue ACO in determining the participation options available to the ACO may disincentivize certain providers from forming ACOs or joining existing ACOs. CMS also believes ACOs inexperienced with performance-based risk Medicare ACO initiatives, regardless of their status as a high- or low-revenue ACO, may be more likely to participate in the program if they are allowed more time under a one-sided model than is currently allowed.

Proposal for a 5-Year Agreement Period under a One-Sided Model for Eligible ACOs. In light of the foregoing considerations and others described in the preamble, CMS is proposing to allow certain ACOs more time under a one-sided model and more flexibility in transitioning to higher levels of risk and potential reward by modifying the participation options available under the Shared Savings Program. Currently participating ACOs, or ACOs that begin an agreement period in Level A or Level B on January 1, 2023, may elect to maintain their participation at Level A or Level B for the remainder of their current agreement period. Because the annual

application and change request cycle will begin before the 2023 PFS final rule is issued, CMS will give ACOs currently participating in Level A or B of the BASIC track glide path the opportunity during the change request cycle to indicate whether they are interested in maintaining their participation at Level A or Level B under this proposed policy, should it be finalized.

All other policies proposed in this section would be effective for agreement periods starting on or after January 1, 2024, unless otherwise noted.

CMS proposes to allow an ACO entering the BASIC track's glide path at Level A that is currently at Level A to elect to remain in Level A for all subsequent performance years of the agreement period—if the following requirements are met:

- 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 or a re-entering ACO that previously participated in the BASIC track's glide path under §425.600(a)(4), and
- The ACO is inexperienced with performance-based risk Medicare ACO initiatives.[6]

This voluntary election could occur prior to the automatic advancement of the ACO to Level B and would be made in the form and manner and by a deadline established by CMS.

In the case of an ACO that elects to remain in Level A for the entirety of its first agreement period, the ACO generally would be eligible to enter into a subsequent agreement period under the BASIC track's glide path, giving the ACO 2 additional years of one-sided risk. Thus, if an eligible ACO made this election and did not elect faster advancement to a higher level of risk and potential reward, the ACO would have 7 years under one-sided risk. Currently, ACOs inexperienced with performance-based risk Medicare ACO initiatives generally are limited to 2 years under a one-sided model, which ACOs have informed CMS is not enough time before transitioning to risk.

CMS also proposes permitting an ACO that is inexperienced with performance-based risk Medicare ACO initiatives to participate in the BASIC track glide path for a maximum of 2 agreement periods (once at Level A for all 5 performance years and a second time in progression on the glide path). This option is limited in that an ACO that enters an agreement at either Level A or Level B is deemed to have completed one agreement under the BASIC track's glide path and is only eligible to enter a second agreement under the BASIC Track's glide path if the ACO continues to meet the definition of inexperienced with performance-based risk Medicare ACO initiatives and satisfies either of the following:

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

[6] CMS notes this would not exclude re-entering former Track 1 ACOs.

CMS proposes that an ACO determined to be inexperienced with performance-based risk Medicare ACO initiatives but not eligible to enter the BASIC track's glide path may enter either the BASIC track Level E for all performance years of the agreement period, or the ENHANCED track.

CMS proposes to amend the definition of performance-based risk Medicare ACO initiative at §425.20 to include only Levels C through E of the BASIC track, removing the one-sided Levels A and B from the definition. CMS further proposes updating the definitions of inexperienced with performance-based risk Medicare ACO initiatives and experienced with performance-based risk Medicare ACO initiatives to allow for a rolling lookback period of the 5 most recent performance years.

In determining an ACO's eligibility to participate under the proposed new participation options, CMS proposes considering only an ACO's experience with performance-based Medicare ACO initiatives, not the ACO's status as a high- or low-revenue ACO. CMS also proposes to make the ENHANCED track optional for all ACOs, regardless of experience with performance-based risk Medicare ACO initiatives, including high-revenue ACOs.

If an ACO meets the definition of experienced with performance-based risk Medicare ACO initiatives, CMS proposes that the ACO would be permitted to complete the remainder of its current performance year in a one-sided model of the BASIC track, but would be ineligible to continue participation in the one-sided model after the end of that performance year if it continues to meet the definition of experienced with performance-based risk Medicare ACO initiatives and would be automatically advanced to Level E of the BASIC track at the start of the next performance year.

CMS seeks comment on the foregoing proposals for ACO participation options in the Shared Savings Program, as well as potential alternatives detailed in the preamble.

Proposal to Remove the Limitation on the Number of Agreement Periods an ACO can Participate in Level E of the BASIC Track. Currently, there are limitations on how long ACOs may participate (if at all) in the BASIC track, including at Level E, the BASIC track's highest level of risk and potential reward. Some ACOs have reported that they would rather leave the program than be required to move to the ENHANCED track and have requested that CMS make the ENHANCED track optional for ACOs. CMS now believes it would be in the best interest of the program and Medicare FFS beneficiaries to permit eligible ACOs to continue participating under the BASIC track Level E, rather than risk significant numbers of experienced, successful ACOs terminating their participation in the program instead of progressing to the ENHANCED track. CMS proposes that if an ACO is determined to be experienced with performance-based risk Medicare ACO initiatives, the ACO may enter BASIC track Level E for all performance years of the agreement period, or the ENHANCED track. These options would be available without regard to the ACO's status as a high- or low-revenue ACO. CMS also proposes that all ACOs would be permitted to participate indefinitely under the BASIC track Level E, or the ENHANCED track.[7]

[7] This would include ACOs currently in the ENHANCED track or that participate under the ENHANCED track in the future. These ACOs would be permitted to enter a new participation agreement under Level E of the BASIC track.

CMS anticipates providing education and offering outreach to ACOs on the available participation options through various methods—including ACO Coordinators, guidance documents, tip sheets, FAQs, and a bi-weekly newsletter.

3. Determining Beneficiary Assignment Under the Shared Savings Program

CMS reviews the evolution of beneficiary assignment to Shared Savings Program ACOs, beginning with the November 2011 rule in which assignment based upon primary care services delivered was established and the initial list of primary care services adopted for that purpose (76 FR 67853). Periodic updates of the list have been made to reflect changing service codes (e.g., addition of chronic care management services) and approaches to beneficiary assignment (e.g., addition of voluntary assignment).

a. Revised Definition of Primary Care Services (§425.400(c))

CMS proposes to add for PY 2023 and subsequent years the following 4 services and provides rationales for adding them to the beneficiary assignment code list. These HCPCS G-codes are proposed for payment under the PFS in sections II.E. and II.F. of the rule where they are discussed in detail. The complete list of codes to be used for Shared Savings Program assignment purposes beginning with PY 2023 is provided at the end of this section.

(1) Prolonged Services

- GXXX2 Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service, each additional 15 minutes

This code would be added to an initial or subsequent nursing facility visit (CPT codes 99306 and 99310, respectively) for each 15-minute increment once the time spent by the physician or non-physician practitioner (NPP) exceeds 95 minutes for an initial visit or 85 minutes for a subsequent visit. CMS believes it appropriate to add this code to the assignment list because its base codes are already included on the list.

- GXXX3 Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service, each additional 15 minutes

This code would be added to an initial or subsequent home or residence visit (CPT codes 99345 and 99350, respectively) for each 15-minute increment once the time spent by the physician or NPP exceeds the times for these visits plus an additional 15 minutes. The base times for these visits have not yet been finalized. CMS believes it appropriate to add this code to the assignment list because its base codes are already included on the list.

(2) Chronic Pain Management Services

- GYYY1 Chronic pain management and treatment, monthly bundle

CMS proposes to add this code to the beneficiary service assignment list, believing it to be similar to existing chronic care management and principal care management services (CPT codes 99430 and 99425, respectively) that are already included on the list. CMS also notes that the monthly bundle includes elements very similar to the elements required for these reference codes (e.g., care plan, medication management, care coordination).

(3) Primary Care Service Codes for Shared Savings Program Beneficiary Assignment as Proposed for PY 2023 and Subsequent Years

CPT Codes

- 96160 and 96161 (administration of health risk assessment).
- 99201 through 99215 (office or other outpatient visit for the evaluation and management of a patient).
- 99304 through 99318 (professional services furnished in a nursing facility; services identified by these codes when furnished in a skilled nursing facility are excluded when reported on claims from Federally Qualified Health Centers or Rural Health Clinics).
- 99319 through 99340 (patient domiciliary, rest home, or custodial care visit).
- 99341 through 99350 (evaluation and management services furnished in a patient's home).
- 99354 and 99355 (add-on codes, for prolonged evaluation and management or psychotherapy services beyond the typical service time of the primary procedure; when the base code is also a primary care service code).
- 99421 through 99423 (online digital evaluation and management)
- 99424 through 99427 (principal care management services)
- 99437, 99487, 99489, 99490, and 99491 (chronic care management services)
- 99439 (non-complex chronic care management).
- 99483 (assessment and care planning for patients with cognitive impairment).
- 99484, 99492, 99493 and 99494 (behavioral health integration services).
- 99495 and 99496 (transitional care management services).
- 99497 and 99498 (advance care planning; excluded when provided in inpatient settings).

HCPCS codes:

- G0402 (Welcome to Medicare visit).
- G0438 and G0439 (annual wellness visits).
- G0442 (alcohol misuse screening service).
- G0443 (alcohol misuse counseling service).
- G0444 (annual depression screening service).
- G0463 (services furnished in Electing Teaching Amendment hospitals).
- G0506 (chronic care management).

- G2010 (remote evaluation of patient video/images).
- G2012 (virtual check-in, 5-10 minutes).
- G2058 (non-complex chronic care management).
- G2064 and G2065 (principal care management services).
- G2212, GXXX2 and GXXX3 (prolonged office or other outpatient evaluation and management services)
- G2214 (Psychiatric collaborative care model).
- GYYY1 and GYYY2 (chronic pain management services)

b. Technical Update to Home and Residence Services (CPT Codes 99341 through 99350)

CMS proposes to incorporate updated CPT guidelines for Home and Residence Services into policies for the Shared Savings Program's primary care service list. The updated guidelines will take effect starting with the CPT 2023 edition to services furnished in assisted living facilities, group homes, custodial care facilities, and residential substance abuse facilities as well as to beneficiary homes. CMS discusses this change more fully in section II.C. of the rule and proposes there to adopt the updated guidelines under Medicare Fee for Service policies for 2023 and subsequent years.

To implement the update, CMS proposes to add a revised list of primary care services at §425.400(c)(1)(vii)(A)(7) for PY 2023 and subsequent years. The revised list will omit prior references to place of service modifier 12 associated with CPT codes 99341-99350, as place of service 12 would no longer describe the beneficiary group receiving these services.[8]

c. Rural Emergency Hospitals (REHs)

CMS states that it is not proposing to adopt special policies for treatment of services furnished in REHs for purposes of beneficiary assignment under the Shared Savings Program. For assignment purposes, CMS plans to treat services provided in REHs in the same manner as hospital outpatient department services are treated currently by the agency.

d. Using CMS Certification Numbers (CCNs) During Beneficiary Assignment

CMS proposes revisions to the process whereby certain facilities are identified for use in beneficiary assignment, including when a facility's CCN enrollment changes during a Shared Savings Program performance year. The revised process would be applicable starting with PY 2023 and subsequent years for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Electing Teaching Amendment (ETA) hospitals, and Method II Critical Access Hospitals (CAHs). The revised process is described below and would be codified in a new section at §425.402(f).

- Before a performance year starts and periodically during the year, CMS will determine the CCNs for all FQHCs, RHCs, Method II CAHs, and ETA hospitals enrolled under the TIN of an ACO participant. This will include all CCNs with an active Medicare

[8] Place of service 12 is defined by CMS as "location, other than a hospital or other facility, where the patient receives care in a private residence."

enrollment and all CCNs having a deactivated enrollment status. These CCNs will be used in determining assignment for the performance year.

- CMS will account for CCN enrollment status changes during the performance year as follows:
  - If a CCN with no prior Medicare claims experience enrolls under the TIN of an ACO participant after the ACO certifies its required annual ACO participant list, CMS will consider services furnished by that CCN when determining beneficiary assignment to the ACO if the ACO has elected preliminary prospective assignment with retrospective reconciliation for that year.
  - Services furnished by a deactivated CCN that is listed as an ACO participant when a performance year starts will be considered in determining beneficiary assignment to the ACO for the applicable performance year or benchmark year.
  - For a CCN enrolled under the TIN of an ACO participant when a performance year starts then enrolls under a different TIN during the year, CMS will continue to treat services billed by the CCN as services furnished by the ACO participant it was enrolled under at the start of the performance year for purposes of determining beneficiary assignment to the ACO for the applicable performance year.

CMS believes the proposed process will more accurately capture changes to providers and suppliers that participate in an ACO for a given performance year. CMS emphasizes the importance both to CMS and ACOs of accurate participant, provider/supplier, and attestation lists for use in beneficiary assignment, quality measurement, and compliance activities.

4. Quality Performance Standard and Reporting Requirements (§425.512)

The Shared Savings Program's quality performance standard is used to determine whether an ACO is eligible to receive shared savings for a performance year (PY). Determination of whether the standard has been met takes into account the number and type of measures for which an ACO reports data and its measure scores. As a result of prior rulemaking, the standard's performance parameters and its associated reporting requirements are set to gradually increase during PY 2023 and PY 2024 before stabilizing for PY 2025 and subsequent years (86 FR 65263). During the transition, ACOs may report either through the CMS Web Interface or using the electronic clinical quality measures (eCQMs) or clinical quality measures (CQMs) of the APM Performance Pathway (APP) of the Merit-based Incentive Payment System (MIPS).[9] Beginning with PY 2025, only the APP reporting mechanism will be available.

In this rule, CMS proposes to add an alternative quality performance standard, base shared savings and loss amounts on sliding scales, and extend the transition period's existing incentive for reporting the APP measures. CMS also proposes to implement a health equity adjustment to ACO quality scores based on beneficiary dual eligibility and residence in a disadvantaged neighborhood. Minor changes are proposed for Web Interface and APP measures. Proposals are made to address interactions between the alternative quality standard and Advanced APM status. CMS invites comment on all proposals, particularly those related to sliding scales for shared

[9] During the transition, if an ACO successfully reports both through the Web Interface and the APP, the higher of its overall quality scores will be used to determine shared savings eligibility and shared savings/loss amounts.

savings and losses. No changes are proposed to the pay-for-reporting performance standard that applies only to ACOs in the first year of their first Shared Savings Program agreement period (§425.512(a)(2)). CMS discusses a process under consideration for reopening ACO financial performance determinations when quality score errors are subsequently discovered through MIPS targeted reviews. Finally, CMS issues Requests for Information (RFIs) related to beneficiary screening for health-related social needs and about adding questions to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey.

a. Alternative Quality Performance Standard

CMS proposes to revise the Shared Savings Program's quality performance standard by adding a new, less stringent "alternative" quality performance standard beginning with PY 2023. Under the proposed standard, an ACO achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least 1 of 4 outcome measures in the APP measure set would be eligible for shared savings. The existing standard would be retained (30th percentile for PY 2023), modified to include the proposed health equity adjustment if finalized (described later in the rule and this summary). Proposed performance parameters of the two standards and their associated reporting requirements are shown in Table 51 of the rule and below. The requirement to field the CAHPS for MIPS survey applies to both the existing and proposed alternative quality performance standards.

Each ACO's performance would be assessed using both standards. An ACO meeting the existing standard would continue to be eligible for the maximum shared savings associated with its track and level (e.g., 50% for BASIC Level E). An ACO that meets only the alternative standard would be eligible to receive shared savings but in a lesser, scaled amount than under the existing standard. An ACO that meets neither the existing or alternative standard would be ineligible for shared savings.

CMS makes this proposal to mitigate the "all-or-none" scoring structure of the existing standard (i.e., maximum shared savings or none), allowing more ACOs to realize at least some shared savings. CMS believes that increasing access to shared savings is particularly important during the ongoing transition to higher performance parameters and will facilitate retention and recruitment of ACOs into the Shared Savings Program.

CMS states similar reasons for making a parallel proposal regarding shared losses accrued by ACOs bearing two-sided risk, discussed further below. If those ACOs meet only the alternative quality performance standard, they would be eligible for reduced repayments of their losses. The reduction would be smaller than had the ACO met the existing standard.

Table 51. Proposed Reporting Requirements and Quality Reporting Standard for PY 2023 and Subsequent PYs
(From Table 51 in the rule with formatting modifications)

	PY 2023	**PY 2024**	**PY 2025 and Subsequent Years**
Quality Reporting Requirements	Report 10 Web Interface measures **or** the 3 APP eCQMs/MIPS CQMs; **and** administer CAHPS for MIPS	Same as PY 2023	Report the 3 APP eCQMs/MIPS CQMs; **and** administer CAHPS for MIPS

Table 51. Proposed Reporting Requirements and Quality Reporting Standard for PY 2023 and Subsequent PYs (From Table 51 in the rule with formatting modifications)			
	PY 2023	**PY 2024**	**PY 2025 and Subsequent Years**
	survey. CMS calculates 2 claims-based measures.		survey. CMS calculates 2 claims-based measures.
Existing Quality Performance Standard Revised to Include the Proposed Health Equity Adjustment	A health-equity adjusted score that is equivalent to or ≥ the **30th percentile** across all MIPS Quality performance category scores (excludes those eligible for facility-based scoring*) **OR** Report 3 APP eCQMs/MIPS CQMs (for each, meet completeness and case minimum requirements); achieve quality performance score equivalent to or >**10th percentile** of performance benchmark on ≥ 1 (of 4) **APP outcome** measures and a score equivalent to or > than the **30th percentile** of performance benchmark on ≥ 1 of 5 remaining APP measures	A health-equity adjusted score that is equivalent to or ≥ the **40th percentile** across all MIPS Quality performance category scores (excludes those eligible for facility-based scoring*) **OR** Report 3 APP eCQMs/MIPS CQMs (for each, meet completeness and case minimum requirements); achieve quality performance score equivalent to or >**10th percentile** of performance benchmark on ≥ 1 (of 4) **APP outcome** measures and a score equivalent to or > than the **40th percentile** of performance benchmark on ≥ 1 of 5 remaining APP measures	A health-equity adjusted score that is equivalent to or ≥ the **40th percentile** across all MIPS Quality performance category scores (excludes those eligible for facility-based scoring*)
Alternative Quality Performance Standard	Fails to meet **2023** criteria above but ACO Quality performance score equivalent to or > than **10th percentile** of performance benchmark on ≥ 1 (of 4) APP outcome measures would allow shared savings (if otherwise eligible) at a lower rate that is scaled by the ACO's quality performance score	Fails to meet **2024** criteria above but ACO Quality performance score equivalent to or > than **10th percentile** of performance benchmark on ≥ 1 (of 4) APP outcome measures would allow shared savings (if otherwise eligible) at a lower rate that is scaled by the ACO's quality performance score	Fails to meet **2025** criteria above but Quality performance score equivalent to > than **10th percentile** of performance benchmark on ≥ 1 (of 4) APP outcome measures would allow shared savings (if otherwise eligible) at a lower rate that is scaled by the ACO's quality performance score
Quality Performance Standard - Standard is NOT Met	If an ACO (1) does not report any of the 10 CMS Web Interface measures or any of the 3 APP eCQMs/MIPS CQMs **and** (2) does not administer a CAHPS for MIPS survey, the ACO will not meet the quality performance standard or the alternative quality performance standard.	Same as PY 2023	If an ACO (1) does not report any of the 3 APP eCQMs/MIPS CQMs **and** (2) does not administer a CAHPS for MIPS survey, the ACO will not meet the quality performance standard or the alternative quality performance standard.
*Facility-based scoring allows certain clinicians (e.g., pathologists) to be scored using their facilities' Hospital Value Based Purchasing Program results.			

b. Scaled Shared Savings (§§425.605 and 425.610)

Beginning with PY 2023, CMS proposes to adopt a sliding scale approach to calculate shared savings for BASIC and ENHANCED track ACOs that meet the proposed alternative quality

performance standard but not the existing standard. The sliding scale approach would be agnostic to the ACO's quality data reporting mechanism (Web Interface or APP). The ACO's quality performance score would be multiplied by the maximum sharing rate allowed by the ACO's track and level, as shown below. CMS plans to use the proposed health-equity adjusted quality performance score, described later in the rule and this summary, for the scaled shared savings calculation. An example calculation is described in section III.G.4.b.(2) of the rule.

Proposed scaled shared savings rate = health-equity adjusted quality score x maximum shared savings rate for ACO track and level

CMS notes that a sliding scale approach to shared savings has been used previously in the Shared Savings Program. To maximize the amount received by each ACO eligible for shared savings, however, CMS replaced the sliding scale with the all-or-none approach during CY 2021 PFS rulemaking. The agency states that its proposal to return to a sliding scale is responsive to stakeholder concerns about declining scores caused by the transition to the APP measure set. Under the APP reporting mechanism (1) ACO performance will be compared to all MIPS eligible clinicians rather than only to other Shared Savings Program ACOs, (2) measures include patient data regardless of payer rather than only Medicare beneficiaries, and (3) small differences in MIPS quality score distributions could markedly change the number of ACOs that qualify for shared savings.

In addition to meeting quality standard and reporting requirements, to be eligible for shared savings, an ACO must first meet the minimum savings rate (MSR) requirement for its track and level. CMS later in the rule proposes to enable certain low-revenue ACOs in the BASIC track to share in savings even if the ACO does not meet its MSR. Criteria for such ACOs are proposed in a new provision at §425.605(h) and would apply to ACOs entering a BASIC track agreement period beginning January 1, 2024 or in subsequent years. An ACO that satisfies the specified criteria and meets the quality reporting standard would be eligible to receive shared savings at one-half of the maximum sharing rate for their track and level. The applicable quality standard used would be the existing standard but modified to utilize the proposed health equity-adjusted performance score. The reader is referred to section III.G.5.f(2) of the rule and to the Financial Methodology section of this summary below for further discussion.

c. Scaled Shared Losses (§425.610)

CMS proposes two revisions to the current sliding scale approach to calculating shared losses for Shared Savings Program ENHANCED track ACOs beginning with PY 2023. First, eligibility for the scaled loss approach would be expanded beyond ACOs meeting the existing quality performance standard to include those meeting the proposed alternative quality standard. Second, the shared loss rate calculation would be modified by replacing the current multiplier (MIPS quality performance category points earned ÷ total available points) with the proposed health-equity adjusted quality performance score, as shown below. The track's 75 percent maximum loss rate and 40 percent minimum loss rate would remain unchanged. An example calculation is described in section III.G.4.b.(3) of the rule.

Proposed scaled shared loss rate = 1 – (health-equity adjusted quality score x 75%)

CMS believes that the proposed changes would make scaled (i.e., smaller) shared losses available to some ACOs that would otherwise face the maximum shared loss rate of 75 percent and would make the formula easier to understand without materially changing the methodology.

d. Interactions Between the Alternative Quality Standard and Advanced APM Status of ACOs

CMS discusses a potential conflict between the proposed alternative standard and the existing criteria for determining Advanced APM status. ACOs in the ENHANCED track and in Level E of the BASIC track that satisfy the existing Shared Savings Program's quality standard also meet the Advanced APM criterion that calls for payment to be contingent upon performance on at least 2 MIPS quality measures, one or more of which must be an outcome measure(s).[10] The APM criterion would not be satisfied by an ACO meeting only the proposed alternative quality performance standard since it requires just one measure. An ACO meeting only the alternative standard could earn scaled shared savings but would no longer qualify as an Advanced APM, and its clinicians would not receive credit towards APM Qualifying Participant status and its associated positive payment adjustments.

CMS notes that the conflict would be eliminated if a change to modify the Advanced APM quality criterion to require only one measure that is also an outcome measure is finalized as proposed in section IV.A.4.a. of the rule. If that proposal is not finalized, CMS plans to consider finalizing an alternative policy that would allow scaled shared savings beginning with PY 2023 and for subsequent years when an ACO (1) scores at or above the 10th percentile on one measure, (2) scores at or above the 30th percentile on a second measure, and (3) one of its two scored measures is an outcome measure. The alternative policy also would satisfy the existing Advanced APM quality criterion and allow the ACO to maintain its Advanced APM status. Concomitantly, if the revised Advanced APM quality criterion is not finalized as proposed, CMS would consider a parallel alternative policy applicable to scaled shared losses incorporating the same 3 elements described for the scaled shared savings policy.

e. Extension of eCQM/MIPS CQM Transition Incentive

CMS proposes to extend the incentive for ACOs to transition from reporting quality data through the CMS Web Interface to using the APP's eCQMs/CQMs measure set. The incentive, currently applicable through PY 2023, allows an ACO to meet the existing quality performance standard by (1) reporting 3 APP eCQMs/MIPS CQMs, meeting completeness and case minimum requirements for each, (2) scoring at or above the 10th percentile on one or more APP outcome measures, and (3) scoring at or above the 30th percentile on one or more of the remaining APP measures. The extension would apply through PY 2024 and for that year would specify scoring at or above the 40th percentile, rather than at the 30th percentile as currently specified.

CMS also requests comment on a related issue. If the MIPS Advanced APM quality criterion is revised as proposed in section IV.A.4.a of the rule (i.e., to require only one measure that is also

[10] Measures not included in the MIPS inventory may satisfy the requirement under certain specified circumstances. See §414.1415(b)(2) and (b)(3).

an outcome measure), CMS is considering incorporating that change into the ACO quality reporting transition incentive by dropping the incentive's 30th or 40th percentile scoring requirement (for PY 2023 and PY 2024 respectively). The net result would be that an ACO could qualify for the incentive – and thereby meet the quality performance standard – for PY 2023 and PY 2024 solely by (1) reporting 3 APP eCQMs/MIPS CQMs, meeting completeness and case minimum requirements for each and (2) scoring at or above the 10th percentile on one or more APP outcome measures.

The quality standard requirements for PY 2025 and subsequent years as proposed do not interact with the proposed MIPS quality criterion revision. To meet the PY 2025 standard an ACO would be required to (1) report 3 APP eCQMs/MIPS CQMs, meeting completeness and case minimum requirements for each and (2) achieve a health-equity adjusted score that is equivalent to or above the 40th percentile across all MIPS Quality performance category scores (excluding those eligible for facility-based scoring).

f. Health Equity Adjustment

CMS proposes to adopt a health equity adjustment into the Shared Savings Program beginning with PY 2023. The adjustment would be incorporated into calculation of quality performance scores and shared savings and losses and into the extreme and uncontrollable circumstances policy. CMS further proposes that ACO eligibility for the adjustment would be determined by the proportion of assigned beneficiaries that are dually eligible or reside in disadvantaged neighborhoods and would be restricted to ACOs with relatively higher quality performance scores. The adjustment would be implemented through two proposed quality performance score adjusters and be capped at 10 points.

CMS believes that the proposed approach would appropriately award delivery of high-quality care to all patients served by an ACO, incent ACOs to include vulnerable patient groups and providers who treat them, reduce healthcare disparities, and extend accountable care relationships to more Medicare beneficiaries. CMS further believes that this approach avoids potential pitfalls of using risk adjustment methods to advance equity such as masking disparities and setting lower quality of care standards for underserved populations.

(1) Identifying Eligible ACOs

CMS proposes that the health equity adjustment would be available only to ACOs that report using the 3 eCQMs/MIPS CQMs of the APP measure set and meet data completeness requirements for each of these all-payer measures. In addition, the ACO would be required to field the CAHPS for MIPS survey. CMS would continue to calculate scores on two claims-based measures. ACOs reporting quality data only through the CMS Web Interface would not be eligible for the adjustment.

(2) Performance Grouping and Measure Performance Scaler

CMS proposes to link ACO eligibility for the health equity adjustment to performance on all 6 APP measures (eCQMs/MIPS CQM, CAHPS, and claims). ACOs would be divided into thirds, creating top, middle, and bottom "performance groups". Groups would be created independently for each of the 6 measures to capture performance variations within ACOs across measures.

Performance grouping also would take reporting mechanism into account. ACOs reporting eCQMs would be compared only to other eCQM reporters and ACOs reporting MIPS CQMs would be compared only to other MIPS CQM reporters. Comparisons for the CAHPS and claims-based measures would take into account all ACOs submitting data for those measures.

CMS proposes to assign a value from zero to 4 for each measure for each ACO: a value of 4 for top performers, 2 for middle performers, and zero for bottom performers. The values would be summed into a "measure performance scaler", ranging from 0 to 24 points. CMS also would assign a value of zero for a measure for which the case minimums or sample size is not met by an ACO. However, CMS would still calculate a measure performance scaler using all measures for which complete data are available as long as data for at least the 3 eCQM/MIPS CQM measures are complete. Example calculations for the measure performance scaler are described in section III.G.4.b(7)(f) and Table 47 of the rule.

CMS indicates having considered other performance value assignment distributions and use of a 0/1/2 value set is discussed in detail. CMS states that the chosen 0/2/4 value set maximizes the health equity adjustment points awarded to high-performing ACOs with larger proportions of beneficiaries from underserved populations.

(3) Underserved Multiplier

CMS proposes to award higher positive health equity adjustments to ACOs with larger proportions of assigned beneficiaries from underserved populations. For this purpose, CMS is proposing to use the proportions of dually eligible beneficiaries and those residing in socioeconomically disadvantaged neighborhoods as reflected through the Area Deprivation Index (ADI).[11] The "underserved multiplier" could range between zero and 1 and would be set as the higher of an ACO's assigned beneficiary population that (1) are dually eligible or (2) reside in a census block group with an ADI national percentile rank of 85 or greater. Both the underserved multiplier and the previously described measure performance scaler would be used in calculating an ACO's health equity adjustment.

CMS believes that dual eligibility more closely reflects characteristics of underserved beneficiaries at the individual level (e.g., income) while the ADI more broadly reflects neighborhood level characteristics (e.g., employment, housing) that may influence the healthcare delivered to the neighborhood's residents.[12] As such, CMS sees the two proportions as complementary adjusters indicating potentially underserved status but with some degree of overlap. By proposing to use the higher adjuster's value, CMS seeks to more fully capture important determinants of healthcare outcomes while minimizing beneficiary double-counting due to overlap.

CMS also considered two alternatives: (1) the underserved multiplier is the sum of the dual and high ADI proportions or (2) the proportion of assigned beneficiaries eligible for the Part D low-

[11] The census block-level ADI is based on a measure created by the Health Resources and Services Administration (HRSA) and refined by researchers at the University of Wisconsin.

[12] CMS states that an ADI percentile rank of 85 or greater has been correlated with worse health outcomes such as increased rates of hospitalizations for conditions including heart failure and pneumonia.

income subsidy (LIS) is added as a third adjuster for consideration – either to replace the dual proportion or used in a three-way comparison of adjuster values to determine the highest value, which would be used. A more detailed discussion is provided in section III.G.4.(7)(a) of the rule. **CMS specifically seeks comment on potential inclusion of the LIS proportion as part of the underserved multiplier.** CMS notes that LIS subsidy eligibility is standardized nationally whereas Medicaid eligibility varies across states. Additionally, CMS notes the ADI represents an all-payer population whereas dual eligibility and the LIS are linked specifically to Medicare as a payor.

(4) Determining Health Equity Adjustment Bonus Points and Health Equity-Adjusted Quality Performance Scores

CMS proposes to apply the health equity adjustment to payment in the form of bonus points added to an ACO's MIPS Quality performance category score (i.e., score for the APP measure set). The bonus points would equal the product of the performance scaler, the underserved multiplier and the performance score, and the sum of the bonus points and the MIPS quality score would be termed the health equity-adjusted quality performance score, as shown below.

Proposed health-equity adjustment bonus points = MIPS Quality performance category score x measure performance scaler x underserved multiplier

Proposed health-equity adjusted quality performance score = MIPS Quality performance category score + health-equity adjustment bonus points

CMS further proposes:

- to cap the health-equity adjustment bonus points at 10,
- to cap the health-equity adjusted quality performance score at 100 percent, and
- to set a floor, such that an ACO with an underserved multiplier of less than 20 percent would be ineligible to receive any bonus points.

CMS estimates that 30 percent of ACOs would have an underserved multiplier above 20 percent and expects that setting a floor of 20 percent would help to direct bonus points towards ACOs caring for significant numbers of underserved beneficiaries, increasing their quality performance scores. CMS anticipates that higher health equity-adjusted scores could enable those ACOs to meet the quality performance standard (or the alternative standard if finalized) and earn shared savings or have their shared losses reduced. Enhanced financial stability could incent these ACOs to remain in the Shared Savings Program and attract to the program new provider groups that care for large numbers of underserved beneficiaries.

(5) Calculation Steps and Examples

In section III.G.4.b(7)(f) of the rule CMS reviews the series of calculations to determine health equity adjustment bonus points and health equity-adjusted quality performance scores and shows examples for each step across a range of ACO characteristics and performances (Tables 47 through 50). The steps followed and the results for example ACO #3 are provided below.

Step 1: Calculate the measure performance scaler. ACO #3 measure scores fall into the top performing group for 3 measures and the middle group for 3 measures. The ACO is assigned a value of 4 for 3 measures and a value of 2 for 3 measures; when summed, the assigned values total to a measure performance scaler of 18.

Step 2: Calculate the underserved multiplier. ACO #3 has a dual eligible beneficiary proportion of 0.3 and a proportion of beneficiaries residing in census blocks with ADIs of 85 or greater of 0.3. The "higher value" is 0.3. which becomes the underserved multiplier.

Step 3: Calculate the health equity bonus points. Multiply the results of steps 1 and 2. ACO #3 is awarded 5.4 bonus points (18 x 0.3).

Step 4: Calculate the equity-adjusted performance score. Add the bonus points to the MIPS Quality category performance score. For ACO #3, 5.4 bonus points are added to its MIPS quality score of 85.0 to give a health equity-adjusted quality performance score of 90.4 for ACO #3.

CMS describes a plan to include the health equity adjustment calculations and their results for an ACO as part of its financial reconciliation reports package if the ACO has reported data for the APP's eCQM/MIPS CQMs, even if the ACO also reported data through the CMS Web Interface.

CMS notes that an ACO submitting both APP and Web Interface measure data will be assigned the higher of its 2 resulting MIPS quality category performance scores. However, if adding the ACO's bonus points to its APP-based performance score results in an equity-adjusted performance score higher than the Web Interface-based quality score, the higher equity-adjusted score will be used as the ACO's quality performance score for determining shared savings eligibility and calculating shared savings and losses. CMS emphasizes that MIPS quality category scoring for the ACO's clinicians uses the higher of the ACO's APP-based or Web Interface-based scores prior to any bonus point addition (i.e., the equity-adjusted quality score is not used when scoring the MIPS Quality performance category at the individual MIPS clinician level).

(6) Extreme and Uncontrollable Circumstances Policy (§425.512(b))

CMS proposes to specify that the health equity-adjusted quality performance score would be taken into consideration when determining the quality performance score and calculating shared savings/shared loss reductions for an ACO that has been affected by extreme and uncontrollable circumstances. CMS notes, however, that substituting the equity-adjusted score for the unadjusted score would have limited impact because the current extreme and uncontrollable circumstances policy already assigns to an affected ACO a MIPS quality performance category score that is sufficient to qualify for shared savings/shared loss reductions (e.g., 30th percentile across MIPS quality measures for PY 2023).

More specifically, CMS also notes that:

- Per existing policy, an affected ACO would qualify for the maximum shared savings rate for its track and level and that is not changed by proposals in this rule.

- Per existing policy, an affected ACO on the ENHANCED track and liable for shared losses already receives a shared loss rate scaled by its quality performance and that is not changed by proposals in this rule.
- For an affected ACO eligible to receive a health equity adjustment as provided for by policies proposed in this rule, the bonus points would be calculated and awarded according to those policies if finalized. If the ACO's health equity-adjusted quality score is higher than the quality performance score assigned to it per existing policy, the equity-adjusted score would replace the policy-based score. In practicality, the ACO would qualify for the maximum savings rate with or without the bonus points.
- For an affected ACO on the ENHANCED track and liable for shared losses, receiving bonus points could potentially produce an equity-adjusted performance score that would reduce losses more than would the performance score assigned per policy. The equity-adjusted score would be used to calculate the shared loss reductions.
- An ACO affected by extreme and uncontrollable circumstances that fails to report quality data via the APP, or whose data do not meet completeness or case minimum requirements, by definition would not meet the proposed eligibility criteria for receiving equity bonus points. Therefore, the affected ACO would be assigned its quality score per policy (e.g., 30th percentile across MIPS quality measures for PY 2023).

g. Summary of Proposals

CMS provides its quality standard and reporting proposals arranged by first applicable performance year in narrative form in section III.G.4.(b)(9) and in tabular form as Table 51 (reproduced earlier in this summary). CMS lists its proposals with their associated regulation text changes in section III.G.4.b(7)(h). **The agency also emphasizes several of its requests for comment on specific aspects of its proposals: (1) the measure performance scaler and its associated value assignments, (2) capping the health equity bonus points at 10, (3) setting a minimum ADI proportion above the 85th percentile to be eligible for bonus points, and (4) the alternative methodologies considered for determining the underserved multiplier (e.g., use of the LIS as an underserved indicator variable).**

h. Shared Savings Program Quality Measure and Benchmark Changes

In Table 52, CMS lists the required measures as finalized for PY 2022 for both the CMS Web Interface and APP measure set quality reporting options. For PY 2023, the measures for both options are largely unchanged from those adopted for PY 2022. The Web Interface option will no longer be available starting with PY 2025.

(1) Web Interface Reporting

CMS notes that measure Q110 *Preventive Care and Screening: Influenza Immunization* is being proposed for removal from the MIPS Quality Measure Inventory for all uses except in the Shared Savings Program beginning with PY 2023 (see Appendix 1 Table Group CC for the detailed rationale for removal). The measure will be retained in the Web Interface set for continued use in the Shared Savings Program. Additionally, changes are proposed to all measures in the Web Interface set including Q110. Many changes are technical specification revisions and others

increase alignment between eCQMs and their corresponding MIPS CQMs. All of the measures, the changes, and rationales for change are described in detail in Appendix 1 Table Group E.

(2) Web Interface Benchmarks

CMS proposes to create benchmarks according to previously established Shared Savings Program policies (found at §425.502(b)) for the measures in the Web Interface set for PYs 2022 through 2024. CMS would accomplish this change by adding new paragraph (a)(6) to §425.512, where the quality performance standard is codified for years beginning on or after January 1, 2021. When use of this measure set by ACOs was extended beyond PY 2021 during CY 2022 PFS rulemaking, CMS inadvertently failed to update the measure benchmarks. Proposing benchmarks now for PY 2022 represents retroactive application of a substantive change and CMS proposes to do so by invoking its authority under section §1871(e)(1)(A) of the Act to apply such changes when failing to do so would not be in the public interest. CMS presents a detailed rationale for using its authority in section III.G.4.c(2) of the rule.

CMS further proposes to score 2 Web Interface measures using flat percentage benchmarks for PY 2022: *Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention* (Q226) and *Preventive Care and Screening: Screening for Depression and Follow-up Plan* (Q134). By so doing, CMS addresses issues of having incorrectly stated during CY 2022 rulemaking that a benchmark would not be created for Q226 and having newly determined that sufficient historical data for benchmarking is lacking for Q134. Policies for applying flat percentage benchmarks are found at §425.502(b)(2). CMS would again apply its authority to make retroactive changes. In support of retroactive change, CMS notes that the proposed changes, if finalized, would increase the number of Web Interface measures on which ACOs could be scored and thereby contribute to their quality performance scores as well as potentially allow them to achieve shared savings. CMS anticipates applying flat percentage benchmarks again for PY 2023 for these 2 measures.

(3) APP Measure Reporting

CMS proposes to retitle the measure *Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS* finalized for PY 2023 to *Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions* and to designate it as quality measure ID# 484. The change is proposed beginning with PY 2023 in order to align measure nomenclature between the Shared Savings Program and the MIPS Quality Inventory. This measure as proposed and the others that would constitute the program's APP measure set for PY 2023 are shown in Table 53 of the rule and below. The set is otherwise unchanged from PY 2022. In the table CMS also identifies the APP outcome measures within the set to facilitate their use to satisfy certain proposed options of the Shared Savings Program's quality performance standard and alternative quality performance standard (shown in Table 51 earlier in the rule and above in this summary).

Table 53: Proposed APP Measure Set for eCQM/MIPS CQM Reporting for Performance Year 2023 (reproduced in part from the rule)			
Measure ID #	**Measure Title**	**Measure Type**	**Performance Standard Outcome Measure?***
Q321	CAHPS for MIPS Survey	Patient-Reported Outcome	No
Q479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Outcome	Yes
Q484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Outcome	Yes
Q001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	Intermediate Outcome	Yes
Q134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	Process	No
Q236	Controlling High Blood Pressure	Intermediate Outcome	Yes
* Yes = can be used to meet "outcome" provisions of the Shared Savings Program's quality performance standard or alternative quality performance standard			

i. Clarifying Unweighted MIPS Score Utilization for Quality Standard Determinations

When reporting quality data using the APP measure set, Shared Savings Program ACOs must achieve specified quality score percentiles on eCQMs/MIPS CQMs in order to meet the Program's Quality performance standard and receive shared savings (e.g., 40th percentile for PY 2025 and subsequent years). During PY 2022 rulemaking, CMS began providing historical data for the relevant score percentiles to guide ACOs when comparing their anticipated quality scores to the percentiles required for earning shared savings. CMS provides historical values because current year percentiles are not calculable until all MIPS data have been submitted (after the first quarter of the following year).

CMS has discovered that the historical reference values published during CY 2022 rulemaking (86 FR 39274 and 86 FR 65271) were erroneously determined using a weighted rather than unweighted distribution of MIPS Quality performance category scores. The unweighted distribution had been used in prior years' calculations, and CMS clarifies that the unweighted distribution will continue to be used in future years. In Table 54 of the rule, CMS provides corrected percentile values for PYs 2018 and 2019 along with properly calculated values for PY 2020. The table is reproduced below with the addition of the erroneously calculated, previously published values.

Table 54: Historical Unweighted MIPS Quality Performance Category Scores (modified by HPA to include previously published values)				
PY	**30th percentile**		**40th percentile**	
	Incorrect	**Correct**	**Incorrect**	**Correct**
2018	83.9	59.30	93.3	70.80
2019	87.9	58.00	95.7	70.82
2020	No value published	63.90	No value published	75.59

j. Reopening Initial Determinations of ACO Financial Performance

Timelines for the Shared Savings Program's financial reconciliation process and for the MIPS targeted review process are not fully aligned. CMS generally releases reconciliation reports in August for the prior PY that include determinations of whether ACOs have met the quality performance standard and are eligible for shared savings or responsible for shared losses. CMS states that MIPS performance feedback reports are issued "typically in the summer". The targeted review period during which an ACO can question its quality category score results opens with receipt of its feedback report and lasts for 60 days, so that all targeted reviews may not be completed until as late as November. As a result of timeline mismatch, an ACO might not discover nor CMS be made aware of MIPS feedback errors that affect ACO performance results until well after an ACO's initial financial determination has been made and during which time CMS may have issued a demand letter to the ACO for recoupment of shared losses.

CMS now describes a standardized approach to reopening ACO financial determinations for good cause – errors resulting from timeline mismatch – that is under consideration by the agency. Under this approach:

1) CMS would not set thresholds for error magnitude or number of ACOs affected that could trigger reopening;
2) Upon learning of a MIPS quality score error, CMS would exercise its reopening discretion (see §425.502) to correct errors affecting shared savings eligibility determination or shared savings/loss amounts; and
3) Once having found good cause to make a correction(s), CMS would apply shared savings or loss changes to the ACO's financial reconciliation during the following year.

CMS notes that the reopening process would not defer the obligation of an ACO that has received a demand notice to repay those shared losses within 90 days of being notified. Any over- or underpayments would be addressed in the following year's financial reconciliation.

CMS seeks comment on this clarification of when it would exercise its discretion to reopen for good cause when either an initial determination or a final agency determination regarding an ACO's financial performance needs to be corrected as a result of any corrections made to MIPS Quality performance category scores that affect the determination of whether an ACO is eligible for shared savings, the amount of shared savings due to the ACO, or the amount of shared losses owed by the ACO.

k. Request for Information (RFI): Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health Measures and Future Measure Development

CMS seeks comment on the potential future inclusion of two new measures in the APP Measure set if they first are adopted into the MIPS Measure Inventory for use in the traditional MIPS program.

Screening for Social Drivers of Health

This process measure is being proposed elsewhere in this rule for inclusion within all of the inventory's specialty measure sets for performance year 2023/payment year 2025 of the traditional MIPS program. It is being specified as a CQM but not as an eCQM at this time. The measure assesses the percentage of adult beneficiaries in a provider's practice who are screened for 5 health-related social needs (HRSNs): food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety. The Measure Applications Partnership (MAP) conditionally supported this measure for rulemaking, and it is not yet endorsed by the National Quality Forum (NQF). The measure as adapted for use in the acute care hospital setting also has been proposed for adoption into the Hospital Inpatient Quality Reporting (HIQR) program for voluntary reporting for CY 2023/FY 2025 payment and mandatory reporting beginning with CY 2024/FY 2026 payment.

Screen Positive Rate for Social Drivers of Health

This structural measure is not being proposed at this time for addition to the MIPS inventory. It has been specified as a CQM but not as an eCQM at this time. It assesses the percentage of screened patients who were screen-positive for each of the 5 HRSNs, so that 5 distinct rates are calculated. The Measure Applications Partnership (MAP) conditionally supported this measure for rulemaking, and it is not yet endorsed by the National Quality Forum (NQF). The measure as adapted for use in the acute care hospital setting also has been proposed for adoption into the Hospital Inpatient Quality Reporting (HIQR) program for voluntary reporting for CY 2023/FY 2025 payment and mandatory reporting beginning with CY 2024/FY 2026 payment.

Besides feedback about adding the two measures described above to the APP measure set for use in the Shared Savings Program, CMS asks additional questions about the measures, listed below.

- How to best implement the measures and how they could further drive health equity and health outcomes under the Shared Savings Program?
- What are the possible barriers to implementation of the measures in the Shared Savings Program?
- What impact would the implementation of these measures in the Shared Savings Program have on the quality of care provided for underserved populations?
- What type of flexibility with respect to the social screening tools should be considered should the measures be implemented? While supporting flexibility, how can CMS advance the use of standardized, coded health data within screening tools?
- Should the measures, if implemented in the future, be considered pay-for-reporting measures?

CMS notes that elsewhere in this rule advance investment payments (prepaid shared savings) are being proposed for Shared Savings Program ACOs that meet specified criteria. One of the

proposed acceptable uses of the payments would be to support strategies to address patient challenges related to social determinants of health.

L. Request for Information (RFI): Addition of New CAHPS for MIPS Survey Questions

CMS poses questions about several potential changes to the current CAHPS for MIPS survey. Shared Savings Program ACOs must administer the survey in order to meet the program's quality performance standard and to be eligible for shared savings.

Personal Experience with Discrimination During Healthcare Delivery

CMS cites study data from 2019 suggesting that roughly 20 percent of adults have experienced discrimination in the health care system. To further explore this topic, CMS asks for input on adding the question and response choices below to the CAHPS for MIPS survey.

> Question: "In the last 6 months, did anyone from a clinic, emergency room, or doctor's office where you got care treat you in an unfair or insensitive way because of any of the following things about you?"
> Responses: Health condition, disability, age, culture, sex (including sexual orientation and gender identity), and income.

This question is being tested in the Medicare Advantage program. Results from that testing will inform the agency's decision making about proposing this CAHPS change through rulemaking.

Price Transparency

CMS seeks feedback on future CAHPS for MIPS survey questions dealing with price transparency and views such questions as consistent with the goals of the No Surprises Act.[13] The survey currently asks "In the last 6 months, did you and anyone on your health care team talk about how much your prescription medicines cost?" CMS is considering adding a more general question such as whether the patient had talked with anyone on their health care team about the cost of health care services and equipment.

Survey Modification for Specialty Group Application

CMS requests input on two options for modifying the CAHPS for MIPS survey to make it more broadly applicable to specialty groups in addition to primary care groups: (1) shortening the survey by removing items relevant only to primary care providers and using the shorter survey with all practitioner groups, or (2) creating a separate shorter survey version for use in assessing specialist care and maintaining the existing longer survey for use with primary care groups.

[13] Title I, Division BB of the Consolidated Appropriations Act, 2021, Pub. L. 116-133.

5. Financial Methodology

a. Overview

In this section of the proposed rule, CMS is proposing modifications to the financial methodologies under the Shared Savings Program. It states that its proposals are aimed at encouraging sustained participation by ACOs in the program and removing barriers for ACOs serving medically complex and low-income populations. Specifically, CMS is proposing to:

- Incorporate a prospective, external factor in growth rates used to update the historical benchmark
- Adjust ACO benchmarks to account for prior savings
- Reduce the impact of the negative regional adjustment
- Calculate county FFS expenditures to reflect differences in prospective assignment and preliminary prospective assignment with retrospective reconciliation
- Improve the risk adjustment methodology to better account for medically complex, high-cost beneficiaries and guard against coding initiatives
- Increase opportunities for low revenue ACOs to share in savings

The proposed rule also discusses alternatives to some of the combinations it proposed. It discusses ongoing concerns about the impact of the PHE for COVID-19 on ACOs' expenditures. It proposes to exclude from the determination of Medicare Parts A and B expenditures for purposes of calculations under the Shared Savings Program a proposed new supplemental payment for Indian Health Service and Tribal hospitals and hospitals located in Puerto Rico. It concludes with a discussion of modifications to 42 CFR part 425, subpart G to incorporate the related proposed changes.

b. Statutory and Regulatory Background on Establishing and Updating the Benchmark and Determining Savings

Section 1899(d)(1)(B)(i) of the Act specifies that, in each year of the agreement period, an ACO is eligible to receive payment for shared savings only if the estimated average per capita Medicare expenditures under the ACO for Medicare FFS beneficiaries for Parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under section 1899(d)(1)(B)(ii) of the Act. Section 1899(d)(1)(B)(ii) of the Act addresses how ACO benchmarks are to be established and updated under the Shared Savings Program. Section 1899(i)(3) of the Act grants the Secretary the authority to use other payment models, including payment models that would use alternative benchmarking and savings determination methodologies, if the Secretary determines that doing so would improve the quality and efficiency of items and services furnished under the Medicare program and that the alternative methodology would result in program expenditures equal to or lower than those that would result under the statutory payment model.

The rules governing the benchmarking calculations and determination of shared savings and losses are set forth in the regulations at 42 CFR part 425, subpart G. In the November 2011 final rule establishing the Shared Savings Program, CMS adopted policies for establishing, updating,

and resetting the benchmark at §425.602. The Shared Savings Program's regulations have since evolved to include different benchmarking methodologies, including modifications to §425.602, and the addition of separate benchmarking policies for ACOs entering a second or subsequent agreement period at §425.603. Benchmarking policies applicable to all ACOs in agreement periods beginning on July 1, 2019, and in subsequent years, are specified in §425.601. Calculations related to determination of shared savings and shared losses are specified in §425.605 for ACOs participating under the BASIC track, and §425.610 for ACOs participating under the ENHANCED track (formerly referred to as Track 3).

In the June 2015 final rule, CMS established Track 3, constituting the program's highest level of risk and potential reward (80 FR 32771 through 32781). In the December 2018 final rule, CMS renamed Track 3 the ENHANCED track (see, for example, 83 FR 67841), and established the BASIC track, which includes a glide path with five Levels (A through E) (83 FR 67841 through 67857). The BASIC track's glide path allows eligible ACOs to begin under a one-sided model and incrementally advance to higher levels of risk and reward.

In the May 8, 2020, COVID-19 IFC (85 FR 27578 through 27582), CMS established adjustments to benchmark and performance year expenditure calculations to address the COVID-19 pandemic as specified under §425.611. In the 2021 PFS final rule (85 FR 84771 through 84785), CMS summarized and responded to public comments received on these adjustments, and finalized the regulation at §425.611 with modifications.

Details on the Shared Savings Program's financial methodology and policies to address the impact of COVID-19 are included in Specifications documents.[14]

c. Strengthening Participation by Reducing the Effect of ACO Performance on Historical Benchmarks, Addressing Market Penetration, and Strengthening Incentives for ACOs Serving Medically Complex and High Cost of Care Populations.

(1) Regulatory Background

To establish an ACO's historical benchmark for an agreement period, CMS uses ACO historical expenditures for beneficiaries that would have been assigned to the ACO in the 3 most recent years prior to the start of the agreement period. As the statute requires the use of historical expenditures to establish an ACO's benchmark, the per capita costs for each benchmark year must be trended forward to current year dollars and then a weighted average is used to obtain the ACO's historical benchmark. Section 1899(d)(1)(B)(ii) of the Act also requires that the benchmark shall be updated by the projected absolute amount of growth in national per capita

[14] See Shared Savings and Losses and Assignment Methodology Specifications Version 10 (cms.gov)

expenditures for Parts A and B services under the original Medicare FFS program. Therefore, in the November 2011 final rule establishing the Shared Savings Program, CMS adopted policies for trending forward expenditures for benchmark year (BY) 1 and BY2 to BY3 dollars (76 FR 67924 and 67925), and for updating the benchmark for each performance year during the ACO's agreement period (76 FR 67925 through 67927).
Over the 10 years since the Shared Savings Program was first established, CMS has used a variety of approaches for determining the trend and update factors to make an ACO's cost target more independent of its own expenditures, including using factors based on national expenditures, regional expenditures, or both.

In the November 2011 final rule establishing the Shared Savings Program, CMS adopted trend and update factor policies at §425.602 based on national FFS expenditures (76 FR 67924 through 67927). It finalized use of a national growth rate in Medicare Parts A and B expenditures for FFS beneficiaries for trending forward BY1 and BY2 to BY3 dollars. It also finalized use of a flat dollar equivalent of the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the Medicare FFS program to update the benchmark for each performance year of the agreement period.

In the June 2015 final rule, CMS adopted policies for resetting the benchmark for ACOs entering a second agreement period in 2016 at §425.603(b) (80 FR 32786 through 32796). These policies addressed concerns about the use of an ACO's prior performance years as benchmark years in second and subsequent agreement periods by weighting each benchmark year equally and incorporating an adjustment to account for the average per capita amount of savings generated during the ACO's prior agreement period. CMS refers to this adjustment as a "prior savings adjustment." This adjustment applied only to ACOs entering a second agreement period beginning in 2016 because it subsequently finalized an alternative methodology incorporating factors based on regional FFS expenditures to establish, adjust and update the benchmark for ACOs beginning a second or subsequent agreement period in 2017 and later years.

In the June 2016 final rule (81 FR 37953 through 37991), CMS modified the benchmarking methodology to finalize an approach that incorporated factors based on regional FFS expenditures when resetting (or rebasing) and updating ACO historical benchmarks, as specified in §425.603(c) through (f). It replaced the national trend factor used in the rebasing methodology with a methodology incorporating regional trend factors. This revised rebasing methodology applied beginning in 2017 to determine rebased historical benchmarks for ACOs renewing for a second or subsequent agreement period under the Shared Saving Program.

In the December 2018 final rule (83 FR 68005 through 68030), CMS adopted policies at §425.601 that expanded the use of regional factors in establishing, adjusting, and resetting historical benchmarks to all ACOs, including ACOs in a first agreement period, for agreement periods beginning on July 1, 2019, or in subsequent years. These policies sought to address concerns about ACOs influencing their own regional trends by using a blend of national and regional trend factors to trend forward BY1 and BY2 to BY3 when determining the historical benchmark under §425.601(a)(5) and a blend of national and regional update factors to update the historical benchmark to the performance year under §425.601(b) (83 FR 68024 through

68030). CMS also established a symmetrical cap on the regional adjustment to the historical benchmark equal to positive or negative 5 percent of the national per capita FFS expenditures for assignable beneficiaries for each enrollment type. CMS also modified the schedule of weights used to phase in the regional adjustment at §425.601(f), to reduce the maximum weight from 70 to 50 percent for all ACOs and to slow the phase-in of weights for ACOs with higher spending than their regional service area.

(2) Overview of Considerations for Modification to the Benchmarking Methodology

CMS proposes a combination of policies to ensure a robust benchmarking methodology that would reduce the effect of ACO performance on ACO historical benchmarks and increase options for ACOs caring for high-risk populations. Specifically, CMS proposes to 1) modify the methodology for updating the historical benchmark to incorporate a prospective, external factor; 2) incorporate a prior savings adjustment in historical benchmarks for renewing and re-entering ACOs; and 3) reduce the impact of the negative regional adjustment. It believes these proposed modifications could serve as "stepping stones" to a longer-term approach to the benchmarking methodology, and they are designed to be consistent with the potential approach for incorporating a methodology for administratively set benchmarks, which is described in the related RFI.

These and the other proposed changes to the Shared Savings Program's benchmarking methodology within this proposed rule, would be applicable to establishing, updating, and adjusting the benchmark for agreement periods beginning on January 1, 2024, and in subsequent years.

(3) Incorporating a Prospective, External Factor in Growth Rates Used to Update the Historical Benchmark

CMS proposes to incorporate a prospectively projected administrative growth factor, a variant of the United States Per Capita Cost (USPCC) referred to in the proposed rule as the Accountable Care Prospective Trend (ACPT), into a three-way blend with national and regional growth rates to update an ACO's historical benchmark for each PY in the ACO's agreement period. CMS believes that incorporating this prospective trend in the update to the benchmark would insulate a portion of the annual update from any savings occurring as a result of the actions of ACOs participating in the Shared Savings Program and address the impact of increasing market penetration by ACOs in a regional service area on the existing blended national-regional growth factor.

CMS would calculate a three-way blend as the weighted average of the ACPT (one-third) and the existing national-regional blend (two-thirds) for use in updating an ACO's historical benchmark between benchmark year (BY) 3 and the PY. The ACPT would be projected by the CMS Office of the Actuary (OACT) and would be a modification of the existing FFS USPCC growth trend projections used annually for establishing Medicare Advantage rates, excluding indirect medical education (IME), disproportionate share hospital (DSH) payments, uncompensated care payments, and the proposed new supplemental payment for Indian Health Service (IHS)/Tribal Hospitals and hospitals located in Puerto Rico, and including payments associated with hospice claims to be consistent with Shared Savings Program's expenditure

calculations. CMS proposes to set the ACPT growth factors for the ACO's entire 5-year agreement period near the start of the agreement period. The ACPT factors would remain unchanged throughout the ACO's agreement period, providing a degree of certainty to ACOs.

CMS considered whether the ACPT component of the blend should express projected growth on a relative basis (as the current two-way national-regional blend operates) or on an absolute (flat) dollar basis. It anticipates that the risk-adjusted flat dollar approach will be more beneficial to ACOs. The flat dollar amounts would be risk adjusted to account for differences in severity and case mix between the ACO's assigned beneficiaries and the national assignable FFS population for each Medicare enrollment type. It is not proposing to adjust the ACPT flat dollar amounts for geographic differences in costs or prices, as it believes that doing so could inadvertently reward higher spending, less efficient ACOs with a higher market share in their regional service area.

CMS illustrates in the proposed rule the four steps it would use to set the annualized growth rate(s) and calculate the ACPT flat dollar amounts(s) that would be included in the three-way blend.

Step 1: Calculate annualized growth rate(s) for agreement period

For step 1, OACT would calculate one or more annualized growth rates for the ESRD population (the ESRD ACPT) and one or more annualized growth rates for the aged/disabled population. These annualized growth rate may either be calculated as a uniform annualized projected rate of growth or as a two or more annualized growth rates over each of the 5 performance years of the 5-year agreement period if CMS determines that a uniform annualized projected rate of growth does not reasonably fit the anticipated growth curve.

Step 2: Express the growth rate(s) for each performance year as flat dollar amounts (the ACPT).

For step 2, CMS would multiply BY3 truncated national per capita FFS expenditures calculated by OACT for the assignable FFS population for a given enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries), by the applicable growth rate to calculate the flat dollar amount of growth for each performance year. Thus, for example, if the truncated national assignable per capita expenditures for a given enrollment type was $13,000, and the projected growth rate for that enrollment type in that year is 5 percent per year, the flat dollar amounts would be:

PY1 flat dollar amount = $13,000 x (1.050 – 1) = $650, and PY5 flat dollar amount = $13,000 x (1.276 – 1) = $3,588251

Step 3: Risk adjust the flat dollar amounts.

In step 3, CMS would multiply the flat dollar amounts for each performance year, for each enrollment type, by the ACO's mean BY3 prospective Hierarchical Condition Category (HCC) risk score for that enrollment type. The risk score used would first be renormalized by dividing by the national mean risk score for the assignable FFS population for that enrollment type identified for the calendar year corresponding to BY3. Risk adjusting the flat dollar amounts would allow for a higher update for ACOs serving a population that is more medically complex

than the national average. If the ACO's BY3 risk score was 1.025, the risk adjusted flat dollar amounts would be:

PY1 flat dollar amount = $650 x 1.025 = $666, and PY5 flat dollar amount = $3,588 x 1.025 =$3,678

Step 4: Re-express risk adjusted flat dollar amounts as relative factors.

The fourth and final step before calculating the three-way blended update factor would be to re-express the risk adjusted flat dollar amount for each enrollment type on a relative basis such that it can be combined in a weighted average with the current two-way blend. CMS would divide the risk adjusted flat dollar amounts computed in Step 3 for a given enrollment type by the ACO's historical benchmark expenditures for that enrollment type. If the historical benchmark expenditures for the enrollment type were $12,000, the final ACPT portion of the blended update factors for this enrollment type would be:

PY1 final ACPT portion of the blended update factor = ($666 / $12,000) + 1 = 1.056, and PY5 final ACPT portion of the blended update factor = ($3,678 / $12,000) + 1 = 1.306

The values in this step would then be combined with the two-way blend to compute the three-way blended update factor. The ACPT would constitute one-third of the total blend, while the remaining two-thirds would consist of the existing two-way blend.

CMS provides an example that results in a higher benchmark which increases the ACO's potential for shared savings and reduces the potential for shared losses, if applicable. It also notes, however, that incorporating the ACPT into a three-way blended update factor could have the potential for mixed effects.

Implementation of a Guardrail to provide protection for ACOs from larger share losses. To address this issue, CMS proposes a "guardrail" to provide protection for ACOs from larger shared losses (or potentially from the negative implications of financial monitoring) based on an updated flexibility to reduce the impact the prospectively determined ACPT portion of the three-way blend if unforeseen circumstances occur during an ACO's agreement period.

CMS would recalculate the ACO's updated benchmark using the national-regional blended factor (two-way blend). If the ACO generates savings using the two-way blend (but not in the three-way blend), the ACO would neither be responsible for shared losses nor eligible for shared savings for the applicable performance year.

It also acknowledges, however that a variety of circumstances could cause actual expenditure trends to significantly deviate from the projections. CMS would retain discretion to decrease the weight applied to the ACPT in the three-way blend (i.e., different than the one-third, absent unforeseen circumstances). It proposes that it would have sole discretion to determine whether unforeseen circumstances exist that would warrant adjustments to these weights.

Impact of Using a Three-Way Blend on Benchmarks. CMS simulated the potential impact of the three-way blend rather than two-way blend and found that, on average, ACOs were better off

over the course of the 5-year agreement period and the ACOs benchmark on average increased more. Specifically, CMS observed that, on average, over the 5-year period used in its modeling, about 65 percent of ACOs operating in markets with high Shared Savings Program had a larger benchmark increase under the three-way blend compared with the two-way blend. This approach also benefited ACOs with high percentages of dual-eligibles, disabled populations, and ACOs operating in rural areas.

CMS seeks comment on its proposal to use a three-way blend that incorporates the ACPT to update an ACO's historical benchmark for agreement periods beginning on January 1, 2024, and in subsequent years. It also seeks comment on the specific elements of this approach, including its proposal to calculate the ACPT on a risk adjusted flat dollar basis, to institute a guardrail to protect ACOs, and to retain discretion to adjust the weight applied to the ACPT and the two-way blend in the event of unforeseen circumstances.

(4) Adjusting ACO Benchmarks to Account for Prior Savings

CMS proposes to incorporate an adjustment for prior savings that would apply in the establishment of benchmarks for renewing ACOs and re-entering ACOs, that were reconciled for one or more performance years in the three years preceding the start of their agreement period. It believes that such an adjustment would help to mitigate the rebasing ratchet effect on an ACO's benchmark. Furthermore, CMS believes that returning dollar value to benchmarks through a prior savings adjustment could help address an ACO's effects on expenditures in its regional service area. CMS would adjust an ACO's benchmark based on the higher of either the prior savings adjustment or the ACO's positive regional adjustment. It would also use a prior savings adjustment to offset negative regional adjustments for ACOs that are higher spending compared to their regional service area. Overall, CMS believes that this proposal would help ensure that high performing ACOs have incentives to remain in the program for the long-term.

CMS proposes to use the following steps to calculate the prior savings adjustment:

Step 1: *Calculate total per capita savings or losses in each performance year that constitutes a benchmark year for the current agreement period.* For each performance year CMS would determine an average per capita amount reflecting the quotient of the ACO's total updated benchmark expenditures minus total performance year expenditures divided by performance year assigned beneficiary person years. CMS would apply certain requirements in determining the amount of per capita savings or losses for each performance year. For example, the per capita savings or losses would be set to zero for a performance year if the ACO was not reconciled for the performance year.

Step 2: Calculate average per capita savings. Calculate an average per capita amount of savings by taking a simple average of the values for each of the 3 performance years as determined in Step 1, including values of zero, if applicable. CMS would use the average per capita amount of savings to determine the ACO's eligibility for the prior savings adjustment as follows:

- If the average per capita value is less than or equal to zero, the ACO would not be eligible for a prior savings adjustment. The ACO would receive the regional adjustment to its benchmark.

- If the average per capita value is positive, the ACO would be eligible for a prior savings adjustment.

Step 3: Apply a proration factor to the per capita savings calculated in Step 2. This would be equal to the ratio of the average person years for the 3 performance years that immediately precede the start of the ACO's current agreement period (regardless of whether these 3 performance years fall in one or more prior agreement periods), and the average person years in benchmark years for the ACO's current agreement period, capped at 1. This ratio would be redetermined for each performance year during the agreement period in the event of any changes to the number of average person years in the benchmark years as a result of changes to the ACO's certified ACO participant list, a change to the ACO's beneficiary assignment methodology selection under §425.400(a)(4)(ii), or changes to the beneficiary assignment methodology.

Step 4: Determine final adjustment to benchmark. Compare the pro-rated positive average per capita savings from Step 3 with the ACO's regional adjustment expressed as a single per capita value by taking a person-year weighted average of the Medicare enrollment type-specific regional adjustment values. As detailed in the proposed rule, CMS would adjust an ACO's benchmark based on the higher of either the prior savings adjustment or the ACO's positive regional adjustment. It would also use a prior savings adjustment to offset negative regional adjustments for ACOs that are higher spending compared to their regional service area.

Tables 55 through 58 present hypothetical examples to demonstrate how the adjustment for prior savings would work in practice. In its simulations using 2020 data, CMS states that no ACOs would receive a lower benchmark and that about 22 percent of all ACOs would receive a higher benchmark under this policy. Among ACOs that receive a higher benchmark, the average net effect on per capita benchmark expenditures would be about $130 measured across each of the four enrollment types.

CMS seeks comment on its proposal to adjust the ACO's historical benchmark for savings generated in the ACO's prior agreement period.

(5) Reducing the Impact of the Negative Regional Adjustment

CMS proposes to institute two policy changes designed to limit the impact of negative regional adjustments on ACO historical benchmarks and further incentivize program participation among ACOs serving high cost beneficiaries. It proposes to reduce the cap on negative regional adjustments from negative 5 percent of national per capita expenditures for Parts A and B services under the original Medicare FFS program in BY3 for assignable beneficiaries to negative 1.5 percent. It also proposes that after the cap is applied to the regional adjustment, to gradually decrease the negative regional adjustment amount as an ACO's proportion of dual eligible Medicare and Medicaid beneficiaries increases or its weighted—average prospective HCC risk score increases.

For negative regional adjustments, CMS also proposes to apply an offset factor based on the following: [A] the ACO's overall proportion of BY3 assigned beneficiaries that are dually eligible for Medicare and Medicaid (including dually eligible ESRD, disabled, and aged

beneficiaries) and [B] the ACO's weighted average prospective HCC risk score for BY3 taken across the four Medicare enrollment types. Specifically, the offset factor would be calculated as:

Offset factor = [A] + ([B] – 1)

This offset factor would be applied to negative regional adjustments after the negative 1.5 percent cap is applied. The offset factor would be subject to a minimum of zero and a maximum of one. It would be calculated as:

Final regional adjustment = Negative regional adjustment x (1 – Offset factor)

The higher an ACO's proportion of dual eligible beneficiaries or the higher its risk score, the larger the offset factor would be and the larger the reduction to the overall negative regional adjustment. If the offset factor is equal to the maximum value of one, the ACO would not receive a negative regional adjustment (that is, the negative weighted average regional adjustment would be fully offset). If the offset factor is equal to the minimum value of zero, the ACO would receive no benefit from the offset factor.

Table 61 in the proposed rule shows a hypothetical example of how a proposed offset factor applied to negative regional adjustments. In its simulations of this proposed policy, CMS found that for ACOs that had a negative regional adjustment under the current policy such an adjustment would have been reduced or eliminated under the proposed policy. It also benefits ACOs that had positive weighted regional adjustment under the current policy but that had at least one enrollment type with a negative regional adjustment. CMS believes that applying the lower cap and the offset factor at the enrollment type level is more straightforward and will have the opportunity to benefit ACOs that may be serving high risk populations in at least one, but not all Medicare enrollment types.

CMS seeks comment on these proposed changes to the calculation of the regional adjustment for agreement periods beginning on January 1, 2024, and in subsequent years.

(6) Alternatives Options for Addressing Concerns about the Effect of an ACO's Assigned Beneficiaries on Regional FFS Expenditures in Establishing, Adjusting, Updating, and Resetting the ACO's Historical Benchmark

CMS also considered alternative options to the three proposals described above in section III.G.5.c.(3) through (5) that would more directly reduce the effect of the ACO's own beneficiaries on its regional FFS expenditures: (1) removing an ACO's assigned beneficiaries from the assignable beneficiary population used in regional expenditure calculations; and (2) expanding the definition of the ACO's regional service area to use a larger geographic area to determine regional FFS expenditures. These related approaches were policies CMS sought comment in the 2022 PFS proposed rule.

Alternative 1: Removing an ACO's assigned beneficiaries from the assignable beneficiary population used in regional expenditure calculations

Under this alternative, CMS would exclude an ACO's assigned beneficiaries from the population of assignable beneficiaries in the ACO's regional service area used to determine the regional FFS expenditures used in all benchmarking calculations including trending and updating the benchmark and calculating the regional adjustment. To remove an ACO's assigned beneficiaries from the regional expenditure calculation, CMS would use the mathematical approach described in the CY 2022 PFS proposed rule (86 FR 39292 and 39293), which is premised on per capita risk adjusted FFS expenditures for all assignable beneficiaries in an ACO's regional service area (a) can be interpreted as a weighted average of per capita risk adjusted FFS expenditures for the ACO's assigned beneficiaries (b) and per capita risk adjusted FFS expenditures for assignable beneficiaries in the region who are not assigned to the ACO (c), where the weight on (b) is the ACO's regional market share and the weight on (c) is one minus the ACO's regional market share. Shown as an equation this is:

(a) = [(b) x (ACO's regional market share)] + [(c) x (1 – ACO's regional market share)].

Thus, to remove the ACO's assigned beneficiaries from the regional expenditure calculation, CMS would insert the applicable values for (a), (b), and regional market share (all data elements already computed under the current benchmarking methodology) into the above equation and solve for (c) by rearranging the equation as follows:

(c) = {(a) – [(b) x (ACO's regional market share)]} / (1 – ACO's regional market share).

CMS believes this approach would pose relatively limited operational burden and many commenters responding to its comment solicitation stated that this solution could work well. It remains concerned, however, that such an approach to remove an ACO's assigned beneficiaries from the assignable population could incentivize ACOs to "cherry-pick" healthier, lower-cost patients and could unfairly penalize ACOs that specialize in more medically complex, higher-cost patients, running counter to one of the core dynamics it seeks to address (86 FR 65300 and 65301). CMS is also concerned that this approach would incentivize market consolidation.

CMS states that if it were to finalize this option, it would potentially need to adjust the weights currently used in calculating the regional adjustment to the historical benchmark. This could occur, for example, if an ACO were serving an assigned population that is markedly healthier than other assignable beneficiaries in the ACO's regional service area. CMS is worried that this could potentially lead to a dramatic increase in program costs as higher regional adjustments could translate into higher shared savings payments.

Alternative 2: Expanding the regional service area

The second alternative CMS considered in place of the package of policies that it is proposing would seek to reduce an ACO's influence on expenditures in its regional service area by expanding the ACO's regional service area. CMS notes that while it did not outline a specific approach in the 2022 PFS proposed rule, it sought comment on basing regional expenditure

calculations on larger geographic areas, such as using State-level data or Core-Based Statistical Area (CBSA)-level data, or a combination of data for these larger geographic areas and county-level data (such as blended county/State expenditures).

MedPAC commented to CMS favoring altering the calculation of regional spending by extending the ACO's regional service area to a larger market area (for example, CBSAs, health service areas, or hospital referral regions) in lieu of removing ACO assigned beneficiaries from the calculation of regional FFS expenditures, noting that expanding an ACO's regional service area would help to reduce an ACO's influence on its regional benchmark calculation without explicitly favoring certain categories of ACOs (for example, historically low spending ACOs). Other commenters also supported expanding the regional service area for the purposes of calculating regional FFS expenditures in cases where ACO market penetration is high – some suggested a threshold of 50 percent.

CMS believes that adopting only this second alternative to expand the regional service area would reduce the impact of an ACO's own expenditures on its regional expenditures without introducing incentives for favorable patient selection or concerns about increased volatility that may result from the first alternative of excluding an ACO's assigned beneficiaries from the population of assignable beneficiaries used to determine regional FFS expenditures. It does not believe, however, that it would be as effective in countering the "ratchet effect" It believes that its proposal to incorporate the ACPT into the growth rates used to update the benchmark would ensure that a portion of the update will remain unaffected by observed FFS spending. Furthermore, it has concerns that use of a market penetration threshold may drive further market consolidation as ACOs seek to meet such a threshold.

It also notes that if it were to finalize this second alternative or a combined approach, there are a number of operational factors that it would need to address with greater specificity, including, but not limited to: what alternative geographic area it would use, whether it would replace county-level data with data based on an alternate geographic area or use a blend, and, if using a blend, at what threshold it would be triggered, and what weights would be applied when aggregating expenditures across geographic areas.

d. Calculating County FFS Expenditures to Reflect Differences in Prospective Assignment and Preliminary Prospective Assignment with Retrospective Reconciliation

Under the current benchmarking methodology, CMS uses risk adjusted county-level FFS expenditures, determined based on expenditures for assignable beneficiaries identified for the 12-month calendar year corresponding to the relevant benchmark or performance year, to calculate factors based on regional FFS expenditures used in establishing, adjusting, and updating the ACO's historical benchmark. CMS believes this approach creates a systematic bias in the calculations using county-level expenditures that favors ACOs under prospective assignment.

To remove the favorable bias and bring greater precision to the calculation of factors based on regional FFS expenditures, CMS proposes to calculate risk adjusted regional expenditures using county-level values computed using an assignment window that is consistent with an ACO's

assignment methodology selection for the performance year. That is, for ACOs selecting prospective assignment, CMS would use an assignable population of beneficiaries that is identified based on the offset assignment window (for example, October through September preceding the calendar year) and for ACOs selecting preliminary prospective assignment with retrospective reconciliation it would continue to use an assignable population of beneficiaries that is identified based on the calendar year assignment window. CMS is not proposing to change the way it would compute national factors that require identifying assignable populations.

To facilitate modeling of the proposed changes, CMS is making available, through the Shared Savings Program website the following data files: risk adjusted county-level FFS expenditures for 2018-2020 calculated based on an assignable population identified using an offset assignment window; and data files with ACO-specific information on the applicable assignment methodology for the corresponding years.[15]

e. Improving the Risk Adjustment Methodology to Better Account for Medically Complex, High-Cost Beneficiaries and Guard Against Coding Initiatives

Currently, for ACOs in agreement periods beginning on or after July 1, 2019, CMS uses prospective HCC risk scores to adjust the ACO's historical benchmark at the time of reconciliation for a performance year to account for changes in severity and case mix for the ACO's assigned beneficiary population between BY3 and the performance year, subject to a cap of positive 3 percent for the agreement period (referred to herein as the "3 percent cap").

Currently, the 3 percent cap is applied separately for the population of beneficiaries in each Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries). That is, any positive adjustment between BY3 and any performance year in the agreement period cannot be larger than 3 percent for any Medicare enrollment type.

CMS developed several options to address concerns raised by stakeholders including, but not limited to, accounting for higher volatility in prospective HCC risk scores for certain enrollment types due to smaller sample sizes and allowing for higher benchmarks than the current risk adjustment methodology for ACOs that care for larger proportions of beneficiaries in aged/dual eligible, disabled and ESRD enrollment types (which are more frequently subject to the cap on risk score growth currently).

The three options that CMS considered would modify the existing 3 percent cap on risk score growth:

1. Account for all changes in demographic risk scores for the ACO's assigned beneficiary population between BY3 and the performance year prior to applying the 3 percent cap on positive adjustments resulting from changes in prospective HCC risk scores, and apply the cap in

[15] See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram?redirect=/sharedsavingsprogram/

aggregate across the four Medicare enrollment types (ESRD, disabled, aged/dual eligible, aged/non-dual eligible);

2. Apply the 3 percent cap in aggregate across the four Medicare enrollment types (ESRD, disabled, aged/dual eligible, aged/non-dual eligible) without first accounting for changes in demographic risk scores for the ACO's assigned beneficiary population between BY3 and the performance year; and

3. Allow the cap on an ACO's risk score growth to increase by a percentage of the difference between the current 3 percent cap and risk score growth in the ACO's regional service area, where the percentage applied would be equal to 1 minus the ACO's regional market share.

After consideration of the options, CMS is proposing the first option to modify the existing 3 percent cap on positive prospective HCC risk score growth, such that an ACO's aggregate prospective HCC risk score would be subject to a cap equal to the ACO's aggregate growth in demographic risk scores between BY3 and the performance year plus 3 percentage points. In other words, CMS would calculate a single aggregate value for the cap equal to the dollar-weighted average growth in demographic risk scores across the four enrollment types plus 3 percentage points. CMS would only apply this cap to prospective HCC risk score growth for a particular enrollment type if the aggregate growth in prospective HCC risk scores, calculated as the dollar-weighted average growth in prospective HCC risk scores across the four enrollment types, exceeds the value of the cap.

To implement the new cap, CMS would follow these steps:

Step 1: Determine demographic risk score growth for each Medicare enrollment type.

Demographic risk score growth is measured as the ratio of the ACO's performance year demographic risk score for an enrollment type to the ACO's BY3 demographic risk score for that enrollment type.

Step 2: Calculate the dollar-weighted average demographic risk ratio across the four enrollment types to obtain a single aggregate dollar-weighted average demographic risk ratio. The dollar weight for each enrollment type would be equal to historical benchmark expenditures for that enrollment type divided by the sum of historical benchmark expenditures across all enrollment types. Historical benchmark expenditures for each enrollment type would be calculated as per capita historical benchmark expenditures for that enrollment type multiplied by the ACO's BY3 assigned beneficiary person years for that enrollment type. The aggregate dollar-weighted average demographic risk ratio would be computed by multiplying the risk ratio for each enrollment type by its respective dollar weight and then summing across the four enrollment types.

Step 3: Calculate the sum of the aggregate dollar-weighted average demographic risk ratio from Step 2 and 0.030. This would represent the aggregate cap.

Step 4: Determine prospective HCC risk score growth for each Medicare enrollment type. Prospective HCC risk score growth would be measured as the ratio of the ACO's performance

year prospective HCC risk score for that enrollment type to the ACO's BY3 prospective HCC risk score for that enrollment type.

Step 5: Calculate the aggregate growth in prospective HCC risk scores. This step requires calculating the dollar-weighted average prospective HCC risk ratio across the four enrollment types to obtain a single aggregate dollar-weighted average prospective HCC risk ratio, using the same dollar weights and the same approach described in Step 2.

Step 6: Determine if the ACO will be subject to the cap. If the ACO's aggregate dollar-weighted average prospective HCC risk ratio determined in Step 5 is less than the aggregate cap determined in Step 3, no cap would apply to the prospective HCC risk ratio for any enrollment type, even if the prospective HCC risk ratio for a given enrollment type is higher than the aggregate cap. If the ACO's aggregate dollar-weighted average prospective HCC risk ratio determined in Step 5 is greater than or equal to the aggregate cap determined in Step 3, proceed to Step 7.

Step 7: Compare the prospective HCC risk ratio for each enrollment type calculated in Step 4 to the aggregate cap determined in Step 3. If the prospective HCC risk ratio for a given enrollment type is greater than the aggregate cap, the prospective HCC risk ratio for that enrollment type would be set equal to the aggregate cap. If the prospective HCC risk ratio for a given enrollment type is less than or equal to the aggregate cap, no cap would apply to the prospective HCC risk ratio for that enrollment type.

The resulting prospective HCC risk ratios would then be multiplied by the ACO's historical benchmark expenditures for the relevant Medicare enrollment type at the time of reconciliation for a performance year to account for changes in severity and case mix for the ACO's assigned beneficiary population between BY3 and the performance year.

Table 63 in the proposed rule provides a numeric example of this proposed methodology for a hypothetical ACO that is determined to be subject to the cap. Table 64 shows an example whether the hypothetical ACO is not subject to the cap.

CMS' modeling suggests that a majority of ACOs that operate in regions with risk score growth in excess of 3 percent for at least one Medicare enrollment type would have had higher updated benchmark under the proposed policy than the current policy.

CMS seeks comment on the proposed changes to the risk adjustment methodology for agreement periods beginning on or after January 1, 2024. CMS also seeks comment on the two alternatives considered. CMS states that it will consider the comments received on these alternative options along with the comments on its proposed changes to the risk adjustment methodology, and may consider adopting one of these alternatives in place of the proposed approach if it concludes that it would better address the concerns with the current risk adjustment methodology.

f. Increased Opportunities for Low Revenue ACOs to Share in Savings

To ensure that ACOs do not receive shared savings payments due to normal year-to-year variations in Medicare beneficiaries' claims expenditures, CMS is required by statute to specify a Minimum Savings Rate (MSR) that first must be attained before making shared savings payments. CMS reviews the history of changes to various MSRs and tradeoffs associated with setting a higher MSR. For example, a higher MSR would provide greater confidence that the shared savings amounts reflect real quality and efficiency gains, but could also discourage potentially successful ACOs (especially physician-organized ACOs and smaller ACOs in rural areas) from participating.

CMS proposes to apply a new approach to low revenue ACOs entering an agreement period in the BASIC track beginning January 1, 2024, and in subsequent years—including new, renewing, and reentering ACOs, in order to provide incentives both for new ACOs to join the Shared Savings Program and for existing ACOs to remain in the program.[16] ACOs in the BASIC track that do not meet the MSR requirement but that do meet the quality performance standard (or the proposed alternative quality performance standard described earlier) would qualify for a shared savings payment if the following criteria are met:

- The ACO has average per capita Medicare Parts A and B fee-for-service expenditures below the updated benchmark.
- The ACO is a low revenue ACO at the time of financial reconciliation for the relevant performance year.
- The ACO has at least 5,000 assigned beneficiaries at the time of financial reconciliation for the relevant performance year.

Eligible ACOs that meet the quality performance standard to share in savings at the maximum sharing rate would receive only half of the maximum shared rate (20 percent instead of 40 percent under Levels A and B, and 25 percent instead of 50 percent under Levels C, D, and E). For eligible ACOs that do not meet the quality performance standard required to share in savings at the maximum sharing rate but meet the proposed alternative quality performance standard, the sharing rate would be further adjusted according to that proposal, which would reinstate a sliding scale approach for determining shared savings using the ACO's quality performance score, including the health equity adjustment bonus points (if finalized) described earlier. **CMS seeks comment on this proposal to expand the criteria ACOs can meet to qualify for shared savings under the BASIC track.**

g. Ongoing Consideration of Concerns about the Impact of the Public Health Emergency (PHE) for COVID-19 on ACOs' Expenditures

Due to the COVID-19 PHE, CMS previously made the following changes affecting the Shared Savings Program (including some required by law):

[16] High revenue ACOs in the BASIC track, ACOs below 5,000 assigned beneficiaries at the time of financial reconciliation, and ACOs in the ENHANCED track would not be eligible for this option. CMS acknowledges that this proposal differs from the eligibility criteria for AIPs, which are limited to ACOs that are new to the Shared Savings Program, because the AIP policy is intent on lowering barriers to entry.

- Offered relief to all ACOs that may have been unable to completely and accurately report quality data for 2019 due to the PHE;
- Allowed ACOs whose current agreement periods expired on December 31, 2020, the option to extend their existing agreement period by 1 year;
- Allowed ACOs in the BASIC track's glide path the option to elect to maintain their current level of participation for PY 2021;
- Adjusted certain program calculations to remove payment amounts for episodes of care for treatment of COVID-19, specifically the following:
    - Calculation of Medicare Parts A and B FFS expenditures for an ACO's assigned beneficiaries for all purposes, including establishing, adjusting, updating, and resetting the ACO's historical benchmark and determining performance year expenditures;
    - Calculation of FFS expenditures for assignable beneficiaries for determining county-level FFS expenditures and national Medicare FFS expenditures;
    - Calculation of Medicare Parts A and B FFS revenue of ACO participants for purposes of calculating the ACO's loss recoupment limit under the BASIC track;
    - Calculation of total Medicare Parts A and B FFS revenue of ACO participants and total Medicare Parts A and B FFS expenditures for the ACO's assigned beneficiaries for purposes of identifying whether an ACO is a high revenue ACO or low revenue ACO and for determining an ACO's eligibility for participation options; and
    - Calculation or recalculation of the amount of the ACO's repayment mechanism.
- Expanded the definition of primary care services for purposes of determining beneficiary assignment to include telehealth codes for virtual check-ins, e-visits, and telephonic communication;
- Suspended Medicare sequestration adjustments;[17]
- Held no ACOs liable for shared losses for performance years 2020 and 2021, as those losses were fully mitigated by the adjustment for "extreme and uncontrollable circumstances," for which the PHE for COVID-19 qualified; and
- Suspended the 2021 application cycle for new applicants.

As a result of forgoing the 2021 application cycle for new applications, agreement periods starting in 2022 are the first agreement periods for which 2020 and 2021 would serve as ACO benchmark years. CMS reviews feedback and potential alternatives for addressing the effects of the PHE on ACO benchmarking calculations. OACT analyses found that sharp declines in spending in 2020 tended to rebound in 2021 such that historical benchmarks averaged across a base period including both 2020 and 2021 would appear to represent a reasonable basis from which to update ACO spending targets going forward.

[17] The sequestration adjustment was phased back in, from April 1 to June 30, 2022, at 1 percent. Starting July 1, 2022, sequestration increased to 2 percent. Fully in effect (2 percent), CMS is required to make a 2 percent reduction to shared savings payments that is applied before applying an ACO's shared savings limit. As a result of the suspension of sequestration in 2020 and 2021, shared savings payments made in 2020 and 2021 were roughly 2 percent higher than they would have been otherwise for ACOs that did not earn shared savings in excess of their shared savings limit.

CMS believes that the current blended national-regional trend and update factors would be sufficient to address and mitigate the impact of the start of the PHE for COVID-19 on benchmark year expenditures. CMS believes the proposal to utilize a three-way blend of the ACPT/national-regional growth rates to update benchmarks (described earlier in this summary) would further mitigate any potential adverse effects of the PHE on historical benchmarks while also protecting against unanticipated variation in performance year expenditures and utilization resulting from a future PHE. **CMS seeks comment on this analysis regarding the impact of the PHE for COVID-19 on Shared Savings Program ACOs' expenditures.**

h. Proposed Supplemental Payment for Indian Health Service and Tribal Hospitals and Hospitals located in Puerto Rico

CMS currently excludes Indirect Medical Education (IME), Disproportionate Share Hospital (DSH) and uncompensated care payments from ACOs' assigned and assignable beneficiary expenditure calculations because CMS does not want to incentivize ACOs to avoid the types of providers that receive these payments, and for other reasons described in earlier rulemaking. In the FY 2023 IPPS/LTCH PPS proposed rule (87 FR 28396 through 28398), CMS is proposing to establish a new supplemental payment for IHS/Tribal hospitals and hospitals located in Puerto Rico, beginning in FY 2023.

In this proposed rule, CMS would exclude these new supplemental payments (if finalized) from the determination of Medicare Parts A and B expenditures for purposes of calculations under the Shared Savings Program, consistent with the treatment of IME, DSH and uncompensated care payments.[18] However, when calculating ACO participant revenue,[19] CMS proposes to include these new supplemental payments (if finalized), also consistent with the treatment of IME, DSH and uncompensated care payments. **CMS seeks comment on this proposed change to account for the new supplemental payments for IHS/Tribal hospitals and hospitals located in Puerto Rico (if finalized) within the Shared Savings Program.**

i. Organization and Structure of the Regulations text within 42 CFR Part Subpart G; Technical and Conforming Changes

CMS notes that to date it has tended to include the entirety of the benchmarking methodology applicable to ACOs, based on their agreement period start date, within a single section of the regulations (42 CFR part 425 subpart G). It notes, however, there are currently a limited number of unused sections within that range and no remaining sections in sequential order following the existing benchmarking sections. This section discusses how it plans to restructure the regulations to incorporate the proposed modifications to the benchmarking methodology. The technical details of its proposed technical and conforming changes can be found in this section.

[18] If included, they would have affected the determination of benchmark and performance year expenditures.
[19] ACO participant revenue is used for determining whether an ACO is a low-revenue or high-revenue ACO, and for determining the revenue-based loss sharing limits under two-sided models of the BASIC track's glide path.

6. Reducing Administrative Burden and Other Policy Refinements

CMS proposes 2 burden reduction proposals related to ACO marketing materials and beneficiary notification requirements. Also proposed are refinements to the SNF 3-day rule waiver process and data sharing regulations. All proposals would begin with PY 2023.

a. Requirements for ACO Marketing Materials (§425.310)

CMS proposes to eliminate the requirement for an ACO to submit marketing materials to CMS for review and approval prior to their dissemination and reorganizes the regulation text of the section on Marketing Requirements. CMS notes that only 1 of 241 marketing items undergoing advance review in 2021 was denied. ACOs will remain subject to sanctions (including termination) if they fail to comply with the requirements of the reorganized section.

The reorganized section will continue to require that marketing materials and activities must (1) utilize CMS template language if available, (2) be non-discriminatory, (3) comply with regulations regarding beneficiary incentives at §425.304, and not be materially inaccurate or misleading. CMS also retains its authority to request the submission by an ACO at any time of its marketing materials and will continue to issue written notices to ACOs if materials are disapproved. ACOs and their participants and providers/suppliers will continue to be obligated to discontinue use of disapproved materials.

b. Beneficiary Notification Requirements (§425.312)

CMS proposes to reduce the frequency with which beneficiary information notices are provided to beneficiaries from annually to a minimum of once per agreement period. The notice must be in the form and manner specified by CMS. At the beneficiary's next primary care service visit or no later than 180 days after the notice has been provided, the beneficiary must be given a meaningful opportunity to engage with an ACO representative and to ask questions. The follow-up communication opportunity may be verbal or written but must be tracked and documented by the ACO. Documentation must be made available to CMS upon request. The communication interaction does not create a billable service.

CMS also proposes to clarify requirements for posting of beneficiary notification signage in facilities where ACO participants furnish services. The signage informs beneficiaries of the availability of standardized written notices about (1) the ACO and its participants, (2) the beneficiary's option to deny sharing of claims data that are identifiable at the beneficiary-level, and (3) the option to designate an ACO provider through the voluntary assignment process.

CMS clarifies that signage must be posted in all ACO facilities whether or not primary care services are furnished therein. CMS further clarifies that only primary care facilities must furnish the standardized written notice upon beneficiary request. Clarifications will be codified in a newly proposed and redesignated section at §425.312(a)(2)(i).

CMS believes the changes are responsive to ACOs' concerns that current notification requirements are redundant and confusing to beneficiaries. CMS also notes its ongoing efforts to improve the clarity and relevance of its template notification materials.

c. SNF 3-day Rule Waiver Process (§425.612)

CMS proposes to streamline the process by which an ACO that bears two-sided risk can request a waiver of the SNF 3-day rule, such that an assigned beneficiary can be discharged to and receive inpatient SNF care without a prior 3-day inpatient hospital stay. The beneficiary must be admitted to a SNF Affiliate of the ACO and the SNF must be rated at 3 stars or higher in the CMS 5-star quality rating system.

To reduce the waiver process burden, CMS proposes to drop the requirement that the ACO submit 3 narratives with its application—communication plan, care management plan, and beneficiary evaluation and admission plan. The ACO would be required to provide to CMS upon request narrative materials about its capacity to manage patients under the waiver if granted. CMS has found that the narrative materials have not added value beyond the information contained in other application documents for use in assessing an ACO's capacity to appropriately and safely implement the waiver. Regulation text changes would be made at §425.612(a)(1)(i)(A).

d. Data Sharing Regulations (§425.702)

CMS proposes to update the regulations that govern data sharing by CMS with ACOs by allowing ACOs operating as organized health care arrangements (OHCA) to request aggregate reports and beneficiary-identifiable claims data reports from CMS.

An OHCA is defined under 45 CFR §160.103 (HIPAA regulations) to include an organized system of health care in which more than one covered entity participates and in which the participating covered entities hold themselves out to the public as participating in a joint arrangement and participate in specified joint activities such as quality assessment and improvement activities and payment activities. CMS notes that joint guidance issued by the Office for Civil Rights and the Office of the National Coordinator for Health Information Technology recognizes that ACOs may operate as OHCAs.

CMS states that operating as an OHCA allows an ACO to (1) share protected health information (PHI) among the covered entities in the OHCA without getting authorization from individuals for purposes of the OHCA's health care operations and (2) share PHI for the health care activities of the OHCA without entering into business associate agreements with each other. CMS also believes that the OHCA structure responds to ACO concerns related to gathering and reporting data on ACO patients who are not Medicare beneficiaries once the required transition to all-payer quality measures (eCQMs/MIPS CQMs) is fully implemented for PY 2025.

7. Seeking Comment on Incorporating an Administrative Benchmarking Approach into the Shared Savings Program

a. Background on Longer Term Approach to Benchmarking under the Shared Savings Program

In this section, CMS seeks comment on an alternative approach to calculating ACO historical benchmarks that would use administratively set benchmarks that are decoupled from ongoing observed FFS spending. It states that benchmarks are a core policy instrument for providing sufficient incentives for ACOs to enter and remain in the Shared Savings Program, with significant implications on impacts to the Medicare Trust Funds. CMS has observed that the benchmarking methodology for the Shared Savings Program and Innovation Center models may include ratchet effects that reduce benchmarks for successful ACOs and jeopardize their continued participation over multiple agreement periods, resulting in selective participation (including limited participation by inefficient ACOs).

CMS states that there are two ways in which the use of factors based on realized FFS spending (which reflects any ACO spending reductions) can lead to lower benchmarks, which it refers to as "ratchet" effects: (1) downward pressure on an individual ACO's benchmark resulting from the impact of its achieved spending reductions on its historical benchmark expenditures, regional adjustment, and update factor; and (2) downward pressure on benchmarks due to program-wide spending reductions across all ACOs. The first type of ratchet effect occurs at the individual ACO level, when an ACO's own savings reduce its benchmark, which can occur when CMS resets the historical benchmark at the start of the ACO's second or subsequent agreement period. The second type of ratchet effect occurs at the program level, where overall program success can apply downward pressure on ACOs' benchmarks through the method for updating benchmarks each performance year for changes in expenditures between Base Year 3 (BY3) and the performance year. MedPAC and researchers are also examining the Shared Savings Program benchmarking methodology and have noted many of the above concerns that eliminating ratcheting effects is essential for the long-term sustainability of the Shared Savings Program.

The RFI seeks to gather information regarding a potential alternative approach to calculating ACO historical benchmarks that would use administratively set benchmarks that are decoupled from ongoing observed FFS spending.

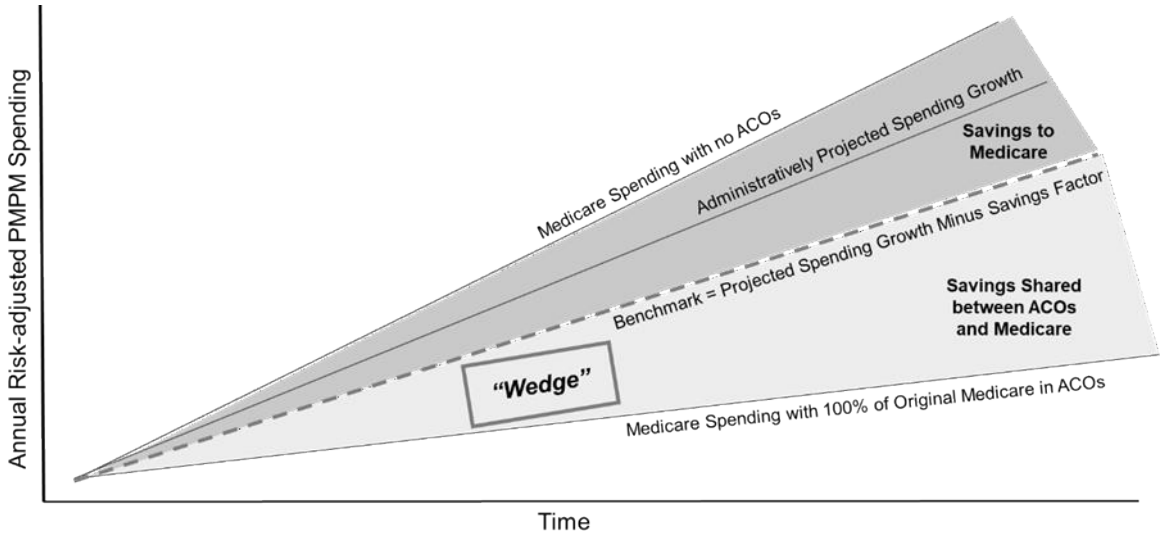
b. Administratively Established Benchmarks as a Potential Solution to Address Benchmarking Concerns

In this section, CMS describes and seeks comment on a direction for future benchmarking that is designed to create a sustainable pathway for long-term program savings for both ACOs and CMS and to address interested parties' concerns around ratcheting. Within this section, CMS provides an overview of and discusses details of key components of this approach.

This approach involves separating benchmarking update factors from realized FFS expenditure growth through the implementation of a prospective, administratively set annual growth rate to update benchmarks. Under this approach, benchmarks would be allowed to rise above realized

FFS expenditure growth as ACOs generate savings, allowing ACOs to retain more of their savings and thus strengthening incentives to participate and achieve savings. Over time, use of this administratively set growth rate would allow for a wedge to accrue between average benchmarks and realized spending reductions, offering greater and more sustainable savings opportunities over the long-term for both Medicare and ACOs. Importantly, average benchmark growth would only exceed realized FFS spending growth to the extent that ACOs reduce spending, such that benchmarks remain at or below FFS spending levels projected in the absence of ACO participation. A graphic depiction of administratively-established benchmarking is provided in Figure 3 in the proposed rule (reproduced below).

Figure 3: Illustrative Example of Administratively-Established Benchmarking Approach



CMS believes that an administrative set benchmarking approach also offers a path for converging benchmarks gradually towards a common risk-adjusted rate in each region, which it anticipates would mitigate selective participation and improve the savings potential of the program. As long as ACOs are generating savings collectively, CMS believes that this approach would allow all ACOs a chance to earn shared savings while reducing overall spending relative to projections and protecting the Trust Funds. In addition, benchmarks that exceed FFS spending would give ACOs flexibility to meet beneficiary needs through alternative modes of care such as virtual care or care management programs that have not traditionally been reimbursed under FFS.

CMS seeks comment on these concepts and on the design of an administratively established benchmarking methodology. It provides more details on its approach in subsequent sections of the proposed rule. It also welcomes comments on the stages for implementing such an approach within the Shared Savings Program, particularly on an initial convergence phase and a post-convergence phase, and any other considerations related to this approach that it has not addressed in this proposed rule. It also seeks comment on any additional modifications to the design of the Shared Savings Program that should be considered in conjunction with administratively set benchmarks.

CMS states that establishing administratively established benchmarks would require it to use its authority under section 1899(i)(3) of the Act. This requires that the alternative payment methodology will improve the quality and efficiency of items and services furnished to Medicare beneficiaries, without resulting in additional program expenditures. **CMS seeks comment on the extent to which the use of administratively set benchmarks might have the potential to improve the quality and efficiency of care furnished to Medicare beneficiaries and any anticipated impact on Medicare expenditures.**

c. Establishing an Administrative Benchmark Update Factor

(1) Overview

Under the administratively-established benchmarking concept, CMS would continue to utilize an ACO's historical FFS expenditures to establish the ACO's historical benchmark. It would modify the existing methodology to fully remove negative regional adjustments to the benchmark, but otherwise retain much of the existing methodology. CMS describes its approach more fully in the subsequent sections.

(2) Use of Accountable Care Prospective Trend in the Benchmark Update

CMS is considering an approach that would transition the proposed three-way blend between the prospective Accountable Care Prospective Trend (ACPT) and retrospectively determined regional and national growth rates (as described in section III.G.5.c. of this proposed rule) to an entirely prospectively set trend. For this trend, OACT would calculate an ACPT, based on a modification of the existing USPCC growth projections used annually for establishing Medicare Advantage rates. It believes that an ACPT with some additional modifications could serve as the core component of the administratively set benchmark update under the longer-term approach.

CMS is considering an approach under which it would establish an ACPT every 5 years which would apply during that 5-year window. It is considering maintaining separate projections within the ACPT for price growth, volume/intensity growth, and demographic factors (with potential exceptions for certain service types such as Part B drugs, which are not currently projected using disaggregated growth assumptions). CMS states that it would also need to establish a process for considering additional factors when recalculating the ACPT prospective update factor every 5 years.

CMS seeks comment on these considerations for calculating an ACPT to be used as an administratively set benchmark update factor. It seeks comment on the 5-year intervals for establishing an ACPT, and alternative approaches that would tie the ACPT to an ACO's agreement period. It also seeks comment on approaches to accounting for price growth and demographic factors versus volume/intensity and considerations for guardrails to protect against projection error. Finally, it seeks comment on approaches to updating the ACPT that would ensure it does not overly reflect ACOs' collective impact on spending.

(3) Discount Factor

CMS believes that under its approach there would need to be a period of gradual convergence in spending between efficient and inefficient ACOs. Its approach would be to subtract a modest

annual discount factor from the fixed 5-year ACPT growth trend based on the relative efficiency of the ACO. For example, if the projected ACPT trend was 5.1 percent annual growth, an ACO with a 0.2 percent discount factor would have a benchmark update factor based on a 4.9 percent annual growth rate (5.1 percent minus 0.2 percent).

To determine what discount would be applied to an ACO's update factor, it would calculate a measure of the ACO's regional efficiency. CMS would compare the ACO's historical spending (the weighted-average spending for the ACO in benchmark year 3) to a regional benchmark (the weighted-average regional FFS expenditures for benchmark year 3). If an ACO's historical spending was greater than its regional benchmark, CMS would apply a discount to the amount of the benchmark update, scaled such that a larger discount is applied for ACOs with increasingly higher spending (less efficient) compared to their regional benchmark. No discount would be applied to the update amount for ACOs with spending 2 percent or more below their regional benchmark. The discount would vary according to the regional efficiency of each participating ACO but, importantly, would not grow if an ACO successfully lowers spending. The calculation would also take into account changes in composition of ACO participant TINs during an agreement period.

CMS seeks comment on this approach for calculating and applying a discount factor in determining the amount of an ACO's benchmark update. It seeks comment on the intervals of the discount described, and alternative approaches such as use of a sliding scale in determining the discount amount. It also seeks comment on approaches to ensuring the discount is reflective of the ACO's regional efficiency, including the approach of recalculating the discount factor to reflect changes in an ACO's regional efficiency as a result of changes in the ACO's composition during its agreement period.

(4) Removal of Negative Regional Adjustments to the Benchmark

In the administratively-established benchmarking concept, CMS would no longer apply negative regional adjustments to the benchmark, although positive regional adjustments would remain. Under this approach, ACOs with higher-than-average historical spending would begin with a benchmark calculated solely using their historical experience. It is also considering approaches for addressing a potential concern that efficient ACOs would be disincentivized from adding less efficient providers and suppliers as ACO participants because it would reduce their regional adjustment. One approach would be to scale an ACO's initial, larger positive regional adjustment based on the overlap in beneficiaries that would have been aligned to the ACO using the ACO's initial ACO participant list and its updated ACO participant list.

CMS seeks comment on this approach, and considerations related to removing the negative regional adjustment in establishing the ACO's historical benchmark under an administratively- established benchmark approach. It also seeks comment on considerations for limiting disincentives for efficient ACOs to add less efficient providers and suppliers.

(5) Detailed Administratively-Established Benchmark Update Calculation

CMS seeks comment on the step-by-step example of the administratively-established benchmark:

Step 1: Calculate the historical benchmark according to the existing Shared Savings Program benchmarking methodology, without applying negative regional adjustments.

Step 2: Risk-adjust the historical benchmark to account for changes in severity and case mix between BY3 and the performance year for each enrollment type.

Step 3: Apply the update factor to the risk-adjusted historical benchmark for each enrollment type, calculated as follows:

++ Start with the overall OACT-projected Shared Savings Program ACPT 5-year projected trend applicable for the ACO based on the start of its agreement period and the performance year for each enrollment type. The update rate over an agreement period may include ACPT projected trends from more than one 5-year period if the ACO's agreement period does not align with the 5-year cycle for ACPT calculation.

++ Apply the average projected trend based on the number of years between BY3 and the performance year.

++ Apply any retrospective adjustments to the trend based on divergence between the price and demographic components of the ACPT projected trend and observed price trends and demographic changes. This retrospective adjustment would be calculated annually after the end of each performance year only for the price and demographic components (no such adjustment would be made for the volume-intensity component).

++ Subtract the relevant discount factor (as per the examples in Table 70, based on the regional efficiency of the ACO in BY3) from the adjusted trend for each year between BY3 and the performance year to determine the ACO's trend percentage.

++ Multiply the ACO's trend percentage by the average national ACPT value for assignment eligible beneficiaries (adjusted to reflect the ACO's relative risk in each eligibility category) to determine the flat dollar update amount.

++ Apply any guardrails as described in section III.G.7.c.(2) of this proposed rule.

++ Add the flat dollar update amount to the ACO's risk-adjusted historical benchmark for the applicable enrollment type.

Step 4: Calculate a single per capita benchmark amount by taking a weighted average across each enrollment type.

d. Convergence to Regional Benchmarks; Post-Convergence Phase

CMS believes that ultimately, this administratively-established benchmark approach would be partially intended to drive ACOs towards regional spending convergence. It believes that this

post-convergence phase would completely eliminate ratcheting effects by removing rebasing and would also decouple benchmarks from an ACO's historical spending, thereby creating a sustainable benchmarking approach that would support high ACO participation levels and reward ACOs for increased efficiency. The convergence phase would be intended to converge benchmarks toward some level above realized spending, but below predicted spending absent ACOs, assuming ACOs generate savings. It anticipates that this convergence phase will last between 5-10 years, depending on participation rates and the pace of spending convergence within regions. If the convergence phase takes longer than 5 years, CMS states that it would need to address the potential rebasing effects for ACOs renewing for subsequent agreement periods under the new benchmarking approach.

CMS seeks comment on—

- Considerations for the design of a regionally consistent benchmarking approach, including how to set fair and accurate risk-standardized benchmarks, the process for annual updates to regional rates, and how to distinguish between enrollment types.
- Considerations for the required conditions and timing for reaching this post-convergence phase with the use of regionally consistent benchmarks, as well as incentives to promote ACO spending convergence within a region.
- Approaches to addressing rebasing effects for renewing and re-entering ACOs in subsequent agreement periods during the convergence phase.
- Considerations for converging to nationally consistent spending versus regionally consistent spending.

e. Request for Comment on Addressing Health Equity Through Benchmarking

CMS states that benchmarks based on historically observed spending may be inequitable to the extent that historical patterns reflect existing inequities in both access to care and the provision of care. It is interested in considering how direct modification of benchmarks to account for existing inequities in care can be used to advance health equity. Direct increases to benchmarks for historically underserved populations would grant additional financial resources to health care providers accountable for the care of these populations, and may work to offset historical patterns of underspending that influence benchmark calculation.

CMS discusses the ACO REACH health equity benchmark adjustment as an example to address inequity in benchmarks calculated primarily using historical expenditures, where historical underspending for underserved beneficiaries informs benchmarks. It believes that these and other approaches could be employed to preserve (if not expand) existing payment differentials that set payment higher for certain providers. Equity-motivated benchmark adjustments could be implemented, for example, to support additional funding for safety net providers (for example, CAHs, RHCs, and FQHCs). In other cases, add-on payments, such as DSH and IME, might continue to be carved out of ACO benchmarks and performance year expenditures, as they are now. **CMS seeks comment on other policy adjustments that should be considered for benchmark setting in the post-convergence phase. This includes:**

- Approaches, generally, to addressing health inequities via the benchmark methodology for the Shared Savings Program, and specifically to incentivize ACOs to serve historically underserved communities.
- Considerations for what data would need to be collected on Medicare beneficiaries and their communities (for example, need for and access to health care providers, transportation, and social services) and what factors should be considered to identify underserved communities and adjust ACO benchmarks.
- Considerations for including a health equity benchmark adjustment in the Shared Savings Program in the near term comparable to the equity adjustment being tested within the ACO REACH Model.
- Considerations for addressing health inequities in the context of the benchmarking concept outlined in this section of this proposed rule.
- Considerations for monitoring and program integrity tools that would track the use of any health equity benchmark adjustments for the intended purposes.
- Considerations for whether benchmark adjustments for ACOs that include CAHs, RHCs, FQHCs, and REHs as ACO participants would improve care for rural and underserved populations and increase participation by these providers and suppliers in the Medicare Shared Savings Program.

8. Impact on Medicare Shared Savings Program

CMS notes that its proposed policies are designed to reverse recent trends where participation has plateaued in the Shared Savings Program, higher spending populations are increasingly underrepresented in the program, and access to ACOs appears inequitable. It believes that the overall increase in shared savings payments to ACOs transitioning to the ENHANCED track appears to be driven largely by favorable regional benchmark adjustments and the track's higher sharing rate. Without modifications, CMS believes that the program is at high risk of increasing overall Medicare spending over the coming decade. Its new proposals are designed to increase program participation for new ACOs through advance investment payments to promote health equity and provide ACO's greater choice in the pace of progression to performance-based risk. It also believes that reducing the cap on negative regional adjustments to high spending ACO benchmarks and offering eligible ACOs a shared savings-only BASIC track participation option for a full 5-year agreement period is expected to significantly re-engage participation for ACOs serving high-cost beneficiaries. This is particularly true for low revenue physician led ACOs for whom a 40 percent sharing rate is a strong incentive for efficiency even absent downside risk.

The proposed rule changes are estimated to reduce overall program spending by $14.8 billion over 12 years relative to the $4.2 billion cost anticipated for the trajectory of the program at baseline, or $10.6 billion in absolute terms relative to a baseline without a Shared Savings Program in FFS Medicare (See Table 142, reproduced below). The impact estimate ranges from a reduction of $8.2 billion to a reduction of $21.4 billion at the 10th an 90th percentiles. CMS anticipates that about 80 percent of advance investment payments are anticipated to be recovered from shared savings payments by the middle of the second agreement period after an initial

investment of $210 million. It also estimates that approximately $60 million in net savings for 2023 is projected for retaining existing higher-spending ACOs that would have otherwise dropped out if not offered the ability to remain in one-sided risk for the remainder of their current agreement period.

Table 142: Proposed Rule Projected Impact Relative to Current SSP Baseline (Financial Impacts in $Millions)

Program Year	ACO Participation	ACO Benchmark	Claims	Net ACO Sharing	Advance Investment Cash Flow*	Comb. Fed Impact
2023	34	10,940	-80	20	N/A	-60
2024	128	40,040	-490	70	210-70	-420
2025	140	43,490	-760	-200	-40	-960
2026	137	44,110	-950	-120	-20	-1,070
2027	138	45,800	-1,170	-70	-10	-1,240
2028	143	49,060	-1,370	-40	-10	-1,410
2029	155	54,930	-1,700	-10	-10	-1,710
2030	146	53,700	-1,990	310	-10	-1,680
2031	144	55,210	-2,110	310	0	-1,800
2032	144	57,130	-2,100	220	0	-1,880
2033	138	56,820	-2,120	250	0	-1,870
2034			-670	-90	0	-760
12Y Total			**-15,510**	**650**	**40**	**-14,810**
Low (10th Ptile)				-3,710		-21,410
High (90th Ptile)				820		-8,200
*Total advance investment payments in 2024 shown with first year repayment amount in same row for 2024						