

Calendar Year (CY) 2023 Medicare Physician Fee Schedule Final Rule - Medicare Shared Savings Program

On November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) final rule that includes changes to the Medicare Shared Savings Program (Shared Savings Program) to advance CMS' overall value-based care strategy of growth, alignment, and equity.

Through the changes we finalized, we seek to reverse certain recent trends^{1,2} in the Shared Savings Program: in recent years growth in the number of beneficiaries assigned to ACOs in the Shared Savings Program has plateaued; higher spending populations are increasingly underrepresented in the program since the change to regionally-adjusted benchmarks; and 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 a Shared Savings Program ACO than their Non-Hispanic White counterparts.

Several of the provisions in this final rule are expected to advance equity within the Shared Savings Program. Based on feedback from health care providers treating rural and 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, we are finalizing policies to advance shared savings payments (referred to as advance investment payments) to low revenue ACOs, inexperienced with performance-based risk Medicare ACO initiatives, that are new to the Shared Savings Program (that is, not a renewing ACO or a re-entering ACO), and that serve underserved populations. These advance investment payments will increase when more beneficiaries who are enrolled in the Medicare Part D low-income subsidy (LIS), are dually eligible for Medicare and Medicaid, live in areas with high deprivation (measured by the area deprivation index (ADI)), or a combination of those, are assigned to the ACO, and these funds will be available to address the social and other needs of people with Medicare. We are also finalizing other modifications to certain existing policies under the Shared Savings Program to support organizations new to accountable care by providing greater flexibility in the progression to performance-based risk,

¹ Refer to CMS, Shared Savings Program Fast Facts - As of January 1, 2022, available at

https://www.cms.gov/sites/default/files/2022-01/2022_Shared_Savings_Program_Fast_Facts.pdf.

¹ Refer to the "Performance Year Financial and Quality Results" Public Use Files available at

<https://data.cms.gov/medicare-shared-savings-program/performance-year-financial-and-quality-results>.

allowing these organizations more time to redesign their care processes to be successful under risk arrangements.

As we seek to increase the percentage of people with Medicare in accountable care arrangements, we are balancing incentives and participation options to serve a dual purpose of sustaining participation by existing ACOs and increasing program growth, recognizing that ACOs vary in their composition of providers/suppliers, the needs of the populations they serve, and have varying degrees of efficiency relative to their region and experience with accountable care initiatives. In this final rule, we are building on the existing Shared Savings Program benchmarking methodology by finalizing modifications to strengthen financial incentives for long-term participation by reducing the impact of ACOs' performance on their benchmarks, to address the impact of ACO market penetration on regional expenditures used to adjust and update benchmarks, and to support the business case for ACOs serving high-risk and high dually eligible populations to participate, which will help sustain participation and grow the program. Additionally, we are finalizing modifications to the benchmarking methodology to mitigate bias in regional expenditure calculations that benefit ACOs electing prospective assignment. The changes we are finalizing to the benchmarking methodology used in the Shared Savings Program align with our consideration of the more long-term benchmarking concepts that would move toward the use of administratively set benchmarks in order to grow and sustain long-term program participation as discussed in the related comment solicitation included in the CY 2023 PFS proposed rule. We are also finalizing policies to expand opportunities for certain low revenue ACOs participating in the BASIC track 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.

We are finalizing changes to the quality reporting and the quality performance requirements that are responsive to interested parties' feedback, and designed to support transition of ACOs to all payer quality measure reporting. These provisions include reinstatement of a sliding scale reflecting an ACO's quality performance for use in determining shared savings for ACOs, regardless of how they report quality data, and to revise the approach for determining shared losses for ENHANCED track ACOs. We are finalizing an extension of the incentive for reporting eCQMs/MIPS CQMs through performance year 2024 to align with the sunset of the CMS Web Interface reporting option. We are also finalizing a health equity adjustment to an ACO's quality performance category score to recognize high quality performance by ACOs with high underserved populations. We are finalizing benchmarking policies to establish quality measure benchmarks and minimum attainment level for the CMS Web Interface measures for performance years 2022, 2023 and 2024 under the Shared Savings Program.

Many of these provisions are the result of our efforts to align policies under the Shared Savings Program and under the Center for Medicare and Medicaid Innovation's (Innovation Center) ACO models. For example, the advance investment payments are derived from learnings from the ACO Investment Model (AIM), an Innovation Center model that tested the effects of making advanced payments of shared savings to certain ACOs participating in the Shared Savings

Program. Incorporation of advance investment payments into the Shared Savings Program payment methodology is an example of how our larger ACO strategy of having the Innovation Center test new payment and service delivery models on the Shared Savings Program “chassis” can better harmonize policies across Medicare ACO initiatives and enable us to scale any findings.

In this final rule, we also summarize comments received in response to the comment solicitation that sought to gather information on a potential alternative approach to calculating ACO historical benchmarks that would use administratively set benchmarks that are decoupled from ongoing observed FFS spending including the design of a potential approach. 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 jeopardizes their continued participation over multiple agreement periods, resulting in selective participation (including limited participation by inefficient ACOs).

Finally, we are finalizing changes that we believe improve the operations of the Shared Savings Program by reducing administrative burden. While ACOs have to continue to comply with marketing material requirements, we are finalizing the elimination of the requirement for an ACO to submit marketing materials to CMS for review and approval prior to disseminating materials to beneficiaries and ACO participants, and modifications to streamline the SNF 3-day rule waiver application review process. We are also finalizing modifications to the beneficiary notification requirements including to reduce the frequency with which beneficiary information notices are provided to beneficiaries from annually to a minimum of once per agreement period, with a follow-up beneficiary communication to promote beneficiary comprehension of the standardized written notice. Further, we are finalizing updates to the data sharing regulations to allow ACOs acting as organized health care arrangements (OHCAs) to request certain aggregate reports and beneficiary-identifiable claims data from CMS. ACOs that choose to structure themselves as OHCAs may reduce their administrative burden when collecting and reporting all-payer eCQMs/MIPS CQMs data to CMS.

This fact sheet summarizes the major changes to the Shared Savings Program that are included in the CY 2023 PFS final rule. Unless specified otherwise, CMS is finalizing its proposed changes to the Shared Savings Program, including changes to the program’s participation options, and quality reporting and performance requirements, and financial methodology, as well as changes to policies within other programmatic areas, including the program’s beneficiary assignment methodology, requirements related to marketing material review and beneficiary notifications, the SNF 3-day rule waiver application, and data sharing requirements. Based on commenters’ suggestions, these final policies include certain refinements to the original proposals, including to incorporate use of LIS enrollment, in addition to dually eligible beneficiary status and ADI score in the methodologies used to determine quarterly advance investment payments and the health equity adjustment for quality performance scores.

We are finalizing as proposed that the initial application cycle for ACOs to apply to enter an agreement period to participate under the modified participation options, including the

opportunity to apply for advance investment payments, and the revised financial methodology including the revised benchmarking methodology, will occur during CY 2023 for a January 1, 2024 start date. More information on how to apply and the application cycle for a January 1, 2024 start date will be available through the [Shared Savings Program's website in the Spring 2023](#).

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

Advance Investment Payments

Given the positive results from the Innovation Center's AIM, and based on our experience with this model, we have finalized, beginning January 1, 2024, a new option in the Shared Savings Program to make advance shared savings payments to certain ACOs. The expectation is that advance investment payments will provide an opportunity for many entities in rural and underserved areas to join together as ACOs, build the infrastructure needed to succeed in the program, and promote equity by holistically addressing beneficiary needs, including social needs. Under the final policy, an eligible ACO that is new to the Shared Savings Program (that is, not a renewing ACO or a re-entering ACO), and identified as being low revenue and inexperienced with performance-based risk Medicare ACO initiatives, may receive a one-time fixed payment of \$250,000 and quarterly payments for the first two years of the 5-year agreement period. Quarterly payments will be based on a score set to 100 if the beneficiary is enrolled in the LIS or is dually eligible for Medicare and Medicaid and otherwise set to the ADI national percentile rank (an integer between 1 and 100) of the census block group in which the beneficiary resides, with higher payment amounts for assigned beneficiaries with a higher risk factors-based score. ACOs will not receive a payment for beneficiaries with a risk factor-based score below 25. Payments will be capped at 10,000 assigned beneficiaries. The advance investment payments will be recouped once the ACO begins to achieve shared savings in their current agreement period and in their next agreement period, if a balance persists. If the ACO doesn't achieve shared savings, we will not recoup the funding, except if the ACO terminates during the agreement period in which it received the advance investment payments. Under the final policy, an ACO must use an advance investment payment to improve the quality and efficiency of items and services furnished to beneficiaries by investing in increased staffing, health care infrastructure, and the provision of accountable care for underserved beneficiaries, which may include addressing social determinants of health. ACOs will also publicly report on their website the amount of any advance investment payments and the actual amount spent in each of the spend plan categories.

Smoothing the Transition to Performance-Based Risk

For agreement periods beginning on January 1, 2024, and in subsequent years, we are finalizing our proposal to allow ACOs inexperienced with performance-based risk to participate in one 5-year agreement under a one-sided shared savings model only by entering the BASIC track's glide path and remaining in Level A for all 5 years. These ACOs may be eligible for a second agreement period within the BASIC track's glide path, with 2 additional years under a one-sided model for a total of 7 years before transitioning to two-sided risk. For performance years

beginning January 1, 2023, and January 1, 2024, we are finalizing our proposal to allow ACOs currently participating in Level A or B the option to elect to continue in their current level of the BASIC track glide path for the remainder of their agreement.

For agreement periods beginning on January 1, 2024, and in subsequent years, we are finalizing our proposal to remove the limitation on the number of agreement periods an ACO can participate in Level E of the BASIC track; participation in the ENHANCED track will be optional.

These changes are responsive to interested parties' concerns that smaller health care providers in rural and underserved settings need additional time to transition to two-sided risk, and that quickly forcing ACOs to adopt two-sided risk models was a barrier to participation in the Shared Savings Program.

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

The following provisions ensure rebased benchmarks remain accurate and serve as a reasonable baseline, when benchmark years correspond to performance years of the ACO's preceding agreement period, requiring ACOs to continually beat their own performance; address a single ACO's or multiple ACOs' collective effects on their own regional expenditures, which are used to calculate the regional adjustment and the regional portion of the trend and update factors; and ensure the benchmarking methodology results in benchmarks of sufficient value to encourage program entry and continued participation by ACOs, ACO participants, and ACO providers/suppliers serving medically complex, high cost populations, and to address selective participation in the program resulting from the program's benchmarking methodology.

We are finalizing a combination of policies to ensure a robust benchmarking methodology that will reduce the effect of ACO performance on ACO historical benchmarks and increase options for ACOs caring for high-risk populations, specifically 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. We believe these 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 was described in the related comment solicitation.

We will monitor the collective impact of the Accountable Care Prospective Trend (ACPT) and other benchmark changes on new and renewing ACOs in order to assess impacts and implementation experience to inform any future refinements, which would be made through future rulemaking.

These changes, and the other changes we are finalizing to the Shared Savings Program’s benchmarking methodology within this final rule, will be applicable to establishing, updating, and adjusting the benchmark for agreement periods beginning on January 1, 2024, and in subsequent years.

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

We are finalizing our proposal to incorporate a prospectively projected administrative growth factor, a variant of the United States Per Capita Cost (USPCC) referred to in this final rule as the ACPT, into a three-way blend with national and regional growth rates to update an ACO’s historical benchmark for each performance year (PY) in the ACO’s agreement period. Incorporating this prospective trend in the update to the benchmark will 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.

A three-way blend will be calculated as the weighted average of the ACPT (one-third) and the national-regional blend (two-thirds) for use in updating an ACO’s historical benchmark between benchmark year (BY) 3 and the PY. The ACPT will be projected by the CMS Office of the Actuary (OACT) and will 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, and the 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.

We are finalizing the proposal 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 will remain unchanged throughout the ACO’s agreement period, providing a degree of certainty to ACOs. We are also finalizing a “guardrail” to provide protection for ACOs from larger shared losses (or potentially from the negative implications of financial monitoring) based on an updated benchmark computed using the three-way blend than would have been experienced under the national-regional blend. This guardrail will not apply to the calculation of shared savings. CMS also retains flexibility to reduce the weight of the prospectively determined ACPT portion of the three-way blend if unforeseen circumstances occur during an ACO’s agreement period.

Adjusting ACO Benchmarks to Account for Prior Savings

We are finalizing our proposal to incorporate an adjustment for prior savings that will 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. Such an adjustment will help to mitigate the rebasing ratchet effect on an ACO’s benchmark by returning to an ACO’s benchmark an amount that reflects its success in lowering growth in expenditures. Furthermore, we believe 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 that result in reducing the regional adjustment added to the historical benchmark. Overall, this provision will help ensure that high performing ACOs have incentives to remain in the program for the long-term. CMS will adjust an ACO's benchmark based on the higher of either the prior savings adjustment or the ACO's positive regional adjustment. We will also use a prior savings adjustment to offset negative regional adjustments for ACOs that are higher spending compared to their regional service area.

Reducing the Impact of the Negative Regional Adjustment

We are finalizing two proposed 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. The first change reduces the cap on negative regional adjustments from negative 5% 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%. The second change is that after the cap is applied to the regional adjustment, to gradually decrease the negative regional adjustment amount as an ACO's proportion of dually eligible Medicare and Medicaid beneficiaries increases or its weighted-average prospective HCC risk score increases.

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

To remove the favorable bias and bring greater precision to the calculation of factors based on regional FFS expenditures, we are finalizing our proposal 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 applicable performance year. That is, for ACOs selecting prospective assignment, we will 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, we will continue to use an assignable population of beneficiaries that is identified based on the calendar year assignment window.

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

We are finalizing modifications to the risk adjustment methodology previously established for ACOs in agreement periods beginning on or after July 1, 2019, under which we use 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% for the agreement period (referred to herein as the "3% cap"). Under the current approach, the 3% 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.

We are finalizing our proposal to 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 to apply the cap in aggregate across the four Medicare enrollment types (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, aged/non-dual eligible Medicare and Medicaid beneficiaries). The revised risk adjustment methodology will be applicable to agreement periods beginning on or after January 1, 2024.

Increased Opportunities for Low Revenue ACOs to Share in Savings

We are finalizing our proposal to expand the eligibility criteria to qualify for shared savings for agreement periods beginning on January 1, 2024, and in subsequent years. This policy will enable certain low revenue ACOs participating in the BASIC track to share in savings even if the ACO does not meet the minimum savings rate (MSR) requirement. Eligible ACOs that meet the quality performance standard required to share in savings at the maximum sharing rate will receive half of the maximum sharing rate for their level of participation (20% instead of 40% under Levels A and B, and 25% instead of 50% 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 alternative quality performance standard being established with this final rule, the sharing rate will be further adjusted according to the finalized sliding scale approach for determining shared savings. We believe this approach will provide payments to ACOs with the greatest need for capital, in particular smaller, rural ACOs which tend to be less capitalized, allowing for investments in care redesign and quality improvement activities. This modification will also align with the other changes we are finalizing to encourage participation by new ACOs and ACOs that focus on underserved populations, such as to offer advance investment payments to new low revenue ACOs joining the BASIC track.

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

CMS's analysis of current data indicates that ACOs exhibiting sharp declines in spending in 2020 tend to show rebounds in spending in 2021 such that historical benchmarks averaged across a base period including both 2020 and 2021 appear to represent a reasonable basis from which to update ACO spending targets going forward. We believe that use of a three-way blend of the ACPT / national-regional growth rates to update benchmarks, as finalized within this final rule for agreement periods beginning on January 1, 2024, and in subsequent years, will further mitigate any potential adverse effects of the PHE for COVID-19 on historical benchmarks while also protecting against unanticipated variation in performance year expenditures and utilization resulting from a future PHE. We will continue to monitor the impact of the PHE for COVID-19 to determine whether any further changes may be necessary to account for the effects of this PHE or future PHEs.

New Supplemental Payment for Indian Health Service and Tribal Hospitals and Hospitals Located in Puerto Rico

As described in the Fiscal Year (FY) 2023 Medicare Hospital Inpatient Prospective Payment Systems (IPPS) / Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) final rule (87 FR 49047 through 49051), we established a new supplemental payment for IHS/Tribal hospitals and hospitals located in Puerto Rico, beginning in FY 2023. Consistent with our policy that excludes disproportionate share hospital and uncompensated care payments from ACO benchmark year expenditures and performance year expenditures, we are finalizing our proposal to exclude these new supplemental payments for IHS/Tribal hospitals and hospitals located in Puerto Rico from the determination of Medicare Parts A and B expenditures for purposes of calculations under the Shared Savings Program and to include the new supplemental payment to IHS/Tribal hospitals and hospitals located in Puerto Rico in Shared Savings Program calculations of ACO participant revenue. This policy is applicable for the performance year beginning January 1, 2023, and subsequent performance years.

Alternative 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

Interested parties have suggested that including an ACO's assigned beneficiaries in the determination of the ACO's regional expenditures results in relatively lower benchmarks for ACOs, particularly ACOs with high market penetration. In the CY 2023 PFS proposed rule, we sought comment on alternative benchmarking policies – a) exclude the ACO's own assigned beneficiaries from the assignable beneficiary population used in regional expenditure calculations; b) expand the definition of the ACO regional service area to use a larger geographic area to determine regional FFS expenditures; or c) both – in order to provide interested parties the opportunity to consider the merits of those alternatives relative to the package of policies we proposed.

We believe the changes to the benchmarking methodology we are finalizing in this final rule will adequately address concerns raised by interested parties about the ability of ACOs with high market penetration to generate shared savings.

We continue to be concerned that serious unintended consequences may arise from removing an ACO's assigned beneficiaries from the assignable beneficiary population used in regional expenditure calculations. We believe such an approach would amplify the benefit to ACOs of selecting lower cost patients and avoiding higher needs groups and drive market consolidation, while still failing to mitigate the problem in cases where multiple ACOs work in combination to drive down regional spending. Furthermore, it would increase program spending to such a degree that compliance with the requirements of section 1899(i)(3) of the Act related to the use other payment models in the Shared Savings Program would be violated.

However, we will continue to explore approaches for expanding the definition of the ACO's regional service area to use a larger geographic area to determine regional FFS expenditures that

could be incorporated into the regional component of the three-way blend we are finalizing with this final rule, and may revisit this topic in future rulemaking.

Transitioning ACOs to All Payer Quality Measure Reporting and Adjusting for Health Equity

Using a Sliding Scale Approach for Determining Shared Savings and Shared Losses Beginning in Performance Year 2023 and Extending the Incentive for Reporting eCQMs/MIPS CQMs for Performance Year 2024

Beginning on January 1, 2023, and subsequent years, we are finalizing to change the all-or-nothing approach to determining an ACO's eligibility for shared savings based on quality performance to allow for scaling of shared savings rates for ACOs that fall below the 30th/40th percentile quality standard threshold required to share in savings at the maximum sharing rate, but who meet minimum quality reporting and performance requirements. Under the final rule, an ACO's quality score for a performance year and the determination of whether the ACO met the Shared Savings Program quality performance standard will affect the determination of shared savings for that performance year and, for ACOs participating in the ENHANCED track, the amount of any shared losses owed. We are finalizing that, beginning with performance year 2023 and for subsequent performance years, if an ACO fails to meet the existing criteria under the quality performance standard to qualify for the maximum sharing rate but the ACO achieves a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set then the ACO will share in savings (if otherwise eligible) at a lower rate that reflects the ACO's quality performance category score. The intent of this approach is to lead to more predictable savings, avoid a cliff whereby small differences in quality scores would lead to elimination of all shared savings, and to promote quality improvement to drive high-quality care for all people with Medicare that receive care at ACOs.

Additionally, we are finalizing to extend the incentive for reporting eCQMs/MIPS CQMs through performance year 2024 to align with the sunsetting of the CMS Web Interface reporting option and allow ACOs an additional year to gauge their performance on the eCQM/MIPS CQMs before full reporting of the measures are required beginning in performance year 2025.

Health Equity Adjustment

We are finalizing our proposal to implement a health equity adjustment of up to 10 bonus points to an ACO's MIPS quality performance category score when reporting all-payer eCQMs/MIPS CQMs and based on (1) high quality measure performance and (2) providing care for a higher proportion of underserved or dually eligible beneficiaries. We will use the area deprivation index (ADI) score, enrollment in the LIS, and Medicare and Medicaid dual eligibility status to assess underserved populations which will allow capturing of broader neighborhood level and individual beneficiary characteristics. The policy will add bonus points to the ACO's MIPS quality performance category score based on a combination of the ACO's performance for each

quality measure and the proportion of their assigned beneficiary population that is underserved. This policy will only positively impact ACOs and not penalize them.

This policy represents one of the first that will promote equity in a value-based care program, while simultaneously avoiding the pitfalls of other pay-for-equity type approaches. This health equity adjustment will not risk adjust away disparities (thereby masking them), and does not set lower quality standards for underserved populations— rather, this provision will reward those providers who provide excellent care for underserved populations. Because the upside-only reward will only go to those providers who serve a minimum percentage of underserved populations, this means that there will also be greater incentive to care for underserved populations. This provision will also address concerns raised by interested parties that in the switch to all-payer eCQMs/ MIPS CQMs that those providers who treat a higher proportion of underserved populations will receive lower quality scores and lower shared savings or higher shared losses as a result. This provision also operates synergistically with the provision to revise the all-or-nothing approach to one of a sliding scale, in that it will possibly lead to higher shared savings or reduced shared losses for a broader array of ACOs treating underserved populations.

Addressing MIPS Quality Performance Category Score Corrections in the Shared Savings Program's Reopening Authority

In this final rule, we are also clarifying that the Shared Savings Program will reopen an ACO's initial determination to correct errors in the MIPS quality performance category score identified through the MIPS targeted review process. In the event that we learn of errors in the calculation of MIPS quality performance category scores (from a MIPS targeted review or some other MIPS quality performance category score-related corrections) that change the percentile score an ACO must achieve in order to meet the quality performance standard, we would exercise our discretion to reopen the initial determination of an ACO's financial performance for good cause to correct errors in 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 due to the miscalculation of MIPS quality performance category scores.

Clarifying the Use of Unweighted MIPS Quality Performance Category Scores for Quality Performance Standard Determinations under the Shared Savings Program

Historically, we have used the unweighted distribution of quality performance category scores submitted by ACOs, groups, and individuals to calculate benchmarks for quality measure performance under MIPS and the Shared Savings Program. We are clarifying that we use the submission level MIPS quality performance category scores (unweighted distribution of scores) to determine the 30th percentile and 40th percentile MIPS quality performance category scores for purposes of establishing the applicable quality performance standard under the Shared Savings Program. We are also clarifying that we use an ACO's submission, which is considered the unweighted distribution of quality performance category scores, to calculate its MIPS quality performance category score for purposes of determining whether the ACO meets the quality performance standard under the Shared Savings Program in performance year 2021 and subsequent performance years, which is consistent with our original intended methodology of using the unweighted distribution based on submission data.

Benchmarking Policies for CMS Web Interface Measures for Performance Years 2022, 2023, and 2024

In the CY 2022 PFS final rule, we extended the CMS Web Interface as a collection type for performance years 2022, 2023 and 2024 for Shared Savings Program ACO's reporting under the APP, however, the benchmarking policies under § 425.502(b) that were used to establish quality measure benchmarks in the Shared Savings Program prior to the development and implementation of the APP were sunset with the 2020 performance year. We are finalizing our proposal to amend the regulation at § 425.512, which governs the ACO quality performance standard for performance years beginning on or after January 1, 2021, to include a new paragraph (a)(6), which will provide that for performance years 2022, 2023, and 2024, CMS designates a performance benchmark and minimum attainment level for each CMS Web Interface measure and establishes a point scale for the measure as described in § 425.502(b). In addition, we are finalizing our proposal to use the approach to set flat percentage benchmarks for the Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID 134) measure and the Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention (Quality ID# 226) measure for performance year 2022.

Reducing Administrative Burden for ACOs

Marketing Materials

ACOs must continue to comply with marketing material requirements and CMS maintains its ability to review marketing materials upon request along with our requirements regarding the content of marketing materials and our ability to issue a compliance action if a marketing material is out of compliance in the future. However, beginning January 1, 2023, ACOs will no longer be required to submit marketing materials for CMS review and approval prior to use.

Beneficiary Notifications

Beginning January 1, 2023, ACOs will be required to provide a beneficiary notice prior to or at the first primary care service visit of the agreement period, rather than annually, and a new follow-up communication that must take place within 180 days after the beneficiary information notice is provided. This follow-up beneficiary communication is designed to promote beneficiary comprehension of the standardized written notice and provide an opportunity for beneficiaries to ask any outstanding questions. We also improved beneficiary notification materials, poster template, and Medicare & You handbook content to make it more beneficiary-friendly to improve comprehension.

We are also finalizing our provision to further clarify that all ACO participant practices and facilities must post signs notifying beneficiaries of their participation in an ACO, and their ability to decline claims data sharing and voluntary align to their primary clinicians. CMS retains the requirement for ACO participants providing primary care services to make the standardized written notice available upon request.

SNF 3-day Rule Waiver Application

Beginning January 1, 2023, ACOs applying for the SNF 3-day rule waiver will no longer be required to provide narratives describing their communication plan, care management plan, and beneficiary evaluation and admission plan. ACOs will be required to submit attestations that they have established the relevant narratives and care plans and that they are available for review upon CMS request.

Data Sharing

Beginning January 1, 2023, updated data sharing regulations will allow ACOs acting as organized health care arrangements (OHCAs) to request certain aggregate reports and beneficiary-identifiable claims data from CMS. This policy change may reduce administrative burden for ACOs that organize as OHCAs and will allow for the timely exchange of patient information across an ACO's continuum of care.

Updates to ACO Beneficiary Assignment Methodology

We are finalizing revisions to the definition of primary care services that are used for purposes of beneficiary assignment, including to incorporate new prolonged services codes and new chronic pain management codes to ensure that the Shared Savings Program assignment methodology remains consistent with billing and coding guidelines. These changes are applicable for the performance year starting on January 1, 2023, and subsequent performance years.

We are also finalizing modifications to our approach for identifying facilities, such as Federally Qualified Health Centers, Rural Health Clinics, Electing Teaching Amendment hospitals, and Method II Critical Access Hospitals, identified by CMS Certification Numbers (CCNs) used to assign beneficiaries, to account for changes in CCN enrollment during the performance year. These updates are applicable for the performance year starting on January 1, 2023, and subsequent performance years.

For a fact sheet on the CY 2023 Quality Payment Program changes, please visit: <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2136/2023%20Quality%20Payment%20Program%20Final%20Rule%20Resources.zip>