

Physician Fee Schedule Final 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 and Coverage Policies; Medicare Shared Savings Program Requirements; Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts; and COVID-19 Interim Final Rules

[CMS-1770-F, CMS-1751-F2, CMS-1744-F2, CMS-5531-IFC]

On November 2, 2022, the Centers for Medicare & Medicaid Services (CMS) placed on public display a final rule relating to the Medicare physician fee schedule (PFS) for CY 2023¹ and other revisions to Medicare Part B policies. The final rule is scheduled to be published in the November 18, 2022 issue of the *Federal Register*. Policies in the final rules will go into effect on January 1, 2023.

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 policies 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 final 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 finalizes its proposal 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) will increase when more beneficiaries who are enrolled in the Medicare Part D low-income subsidy (LIS), dually eligible for Medicare and Medicaid and/or live in areas with high deprivation (measured by the area deprivation index (ADI)),⁴ 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—will be available to address the social needs of people with Medicare, as well as health care provider staffing and infrastructure. CMS says additional modifications will 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 final 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 also finalizes 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 finalizes 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 final rule, CMS says it is accomplishing the following, among others:

- 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;
- Revise the benchmarking methodology to reduce the effect of ACO performance on ACO historical benchmarks, increase opportunities for ACOs caring for medically complex, high cost beneficiaries, and strengthen incentives for ACOs to enter and remain in the program.
- 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 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 policies 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 policies 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 final 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 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

Background. CMS lays out the rationale for the new advance investment payments (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 among 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). Both models required that the only hospital participants be a CAH or a small IPPS hospital.

Each AP ACO 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, although most of the participating ACOs continued in the Shared Savings Program after the AP ACO Model ended. 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 proposed 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.

This new payment option will 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 will be recouped from shared savings the ACO earned, if any.

CMS received hundreds of public comments on its proposal to implement AIP beginning in PY 2024. The majority of commenters expressed support for AIPs, which will enable practices to partner with community-based organizations to identify and meet the needs of underserved beneficiaries. MedPAC supported the AIP and the approach of basing payments on caring for underserved beneficiaries, but cautioned that the impacts of the AIP may not be the same as in the AIM or AP models. MedPAC urged CMS to continue to monitor and evaluate the impact of providing these funds on program spending and quality of care. CMS will monitor and evaluate the impact of AIPs to ensure the program meets the requirements of section 1899(i)(3) of the Act—to improve the quality and efficiency of items and services furnished, and to not result in additional program expenditures.

AIP Eligibility. CMS proposed 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 AIP opportunity 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 (as defined in §425.20);

- 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 ACO-assigned beneficiaries based on the most recent calendar year for which 12 months of data are available).

For calculating high and low revenue status and ACOs' eligibility for participation options (including AIP eligibility), CMS proposed excluding all Parts A and B payments for a beneficiary's episodes of care for treatment of COVID-19.

Comments/Responses: Many commenters supported additional opportunities for ACOs to obtain AIPs, contending that expanding eligibility to existing ACOs would benefit underserved beneficiaries and work to combat health inequities. They stated that AIPs would benefit ACO beneficiaries in underserved communities who lack adequate healthcare access, which is not reflected in the revenue status of an ACO. Several commenters noted that AIP funds should be available to all ACOs to address SDOH and improve health outcomes by providing preventive and social services. CMS agrees that AIPs will improve ACO participation and assist in providing coordinated care to underserved populations, but that expanding AIP eligibility to all ACOs—or even all ACOs that can demonstrate need among their patient populations—is not consistent with the purpose of AIP and would not be an appropriate use of the Trust Funds. CMS states that AIP is intended to help provide start-up funding needed prior to earning shared savings for those ACOs that face difficulty finding such funding, not for providing indefinite support to ACOs or to ACOs of all sizes.

Many commenters advocated expanding AIP eligibility regardless of an ACO's high or low revenue status, contending that the exclusion of high revenue ACOs would preclude many ACOs with key safety-net providers such as teaching hospitals, FQHCs, RHCs, and CAHs. Another commenter noted that the distinction creates a two-tier system for ACOs between physician-led and hospital-led ACOs, leading to reduced participation of hospital-led ACOs. (Most high revenue ACOs include a hospital in their composition and would not be eligible to receive AIPs, according to one commenter.) Some commenters also suggested broadening the eligibility to allow ACOs with participating safety net providers to receive AIPs, even if they did not otherwise meet eligibility criteria. On the other hand, several commenters supported the low revenue eligibility requirement as it captures smaller ACOs with diverse beneficiary populations, which targets safety net providers, those serving underserved communities, and less financially resourced organizations.

CMS agrees that safety-net providers and high revenue ACOs serve vulnerable communities, but disagrees with commenters that CMS should remove the low revenue eligibility criterion. CMS also disagrees that the eligibility criteria penalize high revenue ACOs, as high revenue ACOs should not need advance funding from CMS to increase staffing, improve health care

infrastructure, and provide accountable care for underserved beneficiaries. In addition, CMS notes that the vast majority of FQHCs and RHCs participating in Shared Savings Program ACOs without a hospital are in low revenue ACOs, so CMS does not believe this requirement will preclude participation of FQHCs or RHCs. CMS will monitor the impact of AIP on ACO formation and participation, including the impact on CAHs.

Several commenters advocated that CMS permit ACOs entering the ENHANCED track to be eligible to participate in AIP, to encourage ACOs that have accepted downside risk to implement strategies that would effectively create savings for the program. Other commenters noted that even ACOs experienced with performance-based risk may lack resources to meaningfully address SDOH and overcome health care inequities for underserved beneficiaries. CMS disagrees that ACOs in the ENHANCED track should be eligible for AIPs. ACOs in that track are generally well established and confident in their ability to coordinate care; with effective management and planning, such ACOs should not need additional advance funding from CMS to increase staffing, improve health care infrastructure, and provide accountable care for underserved beneficiaries. Because not all AIPs will be recouped from an ACO, CMS “prefer[s] to finalize more limited eligibility criteria at this time because such a policy is more fiscally prudent.”

Final Decision: CMS is finalizing AIP eligibility criteria without change.

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

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 does not intend for the 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 its spend plan and any challenges or changes in strategy that occur following receipt of AIPs. However, CMS proposed at §425.630(d)(3) that it may review the spend plan at any time and require the ACO to make changes accordingly to its spend plan to comply with §425.630(e)(1).

The ACO would be required to publicly report its spend plan, along with the total amount of AIPs received from CMS for each performance year and an itemization of how the AIPs were actually spent, including expenditure categories, the dollar amounts spent on the various categories, any changes to the spend plan submitted under §425.630(d)(1), and such other information as CMS may specify.

Comments/Responses: Several commenters requested CMS to provide guidance (FAQs, sample applications and templates) for spend plans. CMS responded that it intends to provide further guidance regarding the PY 2024 application process, including the content of the application and specific requirements such as the deadline for submitting applications and the contents of spend plans. CMS will also provide a feedback process to afford an opportunity for the applicant to clarify or revise its application.

Several commenters thought AIP funding should be available to new ACOs that began participating before January 1, 2024—for example, those that began participating in 2023 (“2023 Starters”). CMS understands the commenters’ concerns regarding relatively new, inexperienced ACOs that will not have access to AIPs under this final rule. CMS may address this concern in future rulemaking.

Final Decision: CMS is finalizing its proposed policies without change.

Use and Management of AIPs. Current regulations (§425.308(b)(4)) require ACOs to publicly report the total proportion of shared savings invested in infrastructure, redesigned care processes, and other resources required to support the goals of better health for populations, better care for individuals, and lower growth in expenditures, including the proportion of shared savings distributed among ACO participants. Although current regulations do not require an ACO to spend its shared savings in any particular way, CMS proposed 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 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. For example, CMS provides the following list of potential SDOH strategies:

- Developing or securing transportation services; housing-related services to address housing insecurity or homelessness, home or environmental modifications to support a healthy lifestyle, legal aid services to help patients' address social needs, employment-related services, food-related services, utilities-related supports, services to support personal safety, services to reduce social isolation, services to help patients cope with or address financial strain or poverty, patient caregiver supports;
- Providing remote access technologies, telemonitoring, and meals;
- Ensuring individuals are able to access culturally and linguistically tailored, accessible health care services and supports that meet their needs, partnering with community-based organizations to address SDOH needs; or
- Implementing systems to provide and track patient referrals to available community-based social services that assess and address social needs, as well as enable coordination and measurement of health and social care across the community where beneficiaries reside.

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 prohibited 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.

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 proposed 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.

Comments/Responses: While expressing support for increased staffing as an appropriate use of AIPs, some commenters suggested permitting investments in training and education, as well. In healthcare workforce shortage areas, where eligible ACOs may face challenges recruiting additional staff, it may be possible for existing staff to be trained and educated to improve the quality and efficiency of services furnished to ACO beneficiaries. CMS stated its belief that providing additional training and education to existing staff working with the ACO would constitute an investment in health care provider infrastructure, and therefore, be a permissible use of AIP funds. Such funding can be used for a wide variety of ACO staffing needs, including health equity officers, peer support specialists, peer recovery specialists, behavioral health clinicians, case managers, community health workers, and other health care professionals with training in delivering culturally and linguistically tailored services.

A few commenters encouraged CMS to consider allowing physician-led ACOs to use AIPs to pay for retention bonuses of clinical and administrative staff. According to one commenter, independent practices often compete with larger provider networks and hospital systems in attracting and maintaining qualified staff members. While CMS appreciates the concerns raised, after further consideration, it does not believe that the payment of retention bonuses should be an allowable use of AIP funds because of the potential for abuse. However, CMS may consider this issue in future rulemaking that would promulgate appropriate safeguards against abuse.

Some commenters supported CMS proposals to use AIPs to help close the health equity gap, recognizing CMS' efforts to reduce health inequalities by implementing SDOH measures in a regulatory program and in implementing AIPs to help support and develop community health partnerships. Commenters suggested that CMS consider incentivizing (or requiring) ACOs to invest a portion of their AIPs in community resources where they are most needed, aligned with their decile—for example, ACOs in Area Deprivation Index (ADI) decile 1-2 must spend 5 percent on community resources, whereas those in deciles 9-10 must spend 25 percent).

In response, CMS noted that ACOs can use AIP funding to assist in developing new strategies to identify underserved beneficiaries and connect them to additional resources, including in the many ways listed by CMS for the appropriate use of AIP funds to address social needs. CMS disagrees with the commenters who advocated that CMS should incentivize or require ACOs to invest a portion of their AIPs in community resources, preferring instead to establish fundamental parameters for the use of AIPs and ACO discretion. However, CMS reiterates that it reserves the right to review any ACO SDOH strategies as part of the spend plan to determine whether such strategies would constitute a prohibited use of AIP funds. If CMS finds that an ACO's planned spending on SDOH will not (or is unlikely to) improve the quality and efficiency of items and services furnished to beneficiaries, it will require the ACO to make changes.

One commenter requested clarification that AIP funds could be used to invest in partnerships with community-based providers, including community pharmacies, where beneficiaries may be connected with additional services. CMS does not believe it is appropriate (or necessary) to use AIPs—an advance payment of shared savings with Trust Fund dollars that should be repaid—to

obtain an ownership or investment interest in a provider, supplier, or pharmacy. Depending on the circumstances, an ACO may use AIP funds to enable a community-based provider, supplier, or pharmacy to improve the quality and efficiency of care furnished to beneficiaries by investing in increased staffing, health care infrastructure, and the provision of accountable care for underserved beneficiaries. However, CMS notes that any such arrangement must comply with all applicable laws and regulations, including the fraud and abuse laws.

Many commenters noted that the AIPs would not provide enough resources to help FQHC-led ACOs acquire the necessary health IT to build analytics and care coordination infrastructure at the ACO and individual health center level; FQHCs experience different challenges from other safety-net providers when transitioning into value-based care models based on FQHC statutory reimbursement requirements under the PPS. Commenters contended that health centers need flexible funding to build capacity at the provider level for care coordination, chronic disease management, and screening for social determinants of health, and that ACOs should be permitted to transfer AIPs to FQHC participants to support building the appropriate infrastructure and workforce to support sustainability. CMS believes that the AIPs' allowable uses provide enough flexibility for ACOs to determine the best way to support the needs of their beneficiaries seeking care at facilities participating in the ACO, which may include contributing toward health IT used by FQHCs—if such support is structured to comply with the fraud and abuse laws and all other applicable laws and regulations.

Final Decision: CMS is finalizing its proposed policies without change regarding the use and management of AIPs.

AIP Methodology. During the first 2 performance years of the ACO's participation agreement, AIPs would include (1) a one-time fixed payment of \$250,000 and (2) 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.

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.

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. The 17 variables used to construct the 2019 ADI are shown in Table 52, reproduced below. Additional background information on the ADI appears in the rule.

TABLE 52. 17 Input Variables from Census Data for the 2019 ADI

Domain	Variable
Education	% Population aged 25 years or older with less than 9 years of education
	% Population aged 25 years or older with at least a high school diploma
	% Employed population aged 16 years or older in white-collar occupations
Income/Employment	Median family income in US dollars
	Income disparity
	% Families below Federal poverty level
	% Population below 150% of Federal poverty level
	% Civilian labor force population aged 16 years and older who are unemployed
Housing	Median home value in US dollars
	Median gross rent in US dollars
	Median monthly mortgage in US dollars
	% Owner-occupied housing units
	% Occupied housing units without complete plumbing
Household Characteristics	% Single-parent households with children younger than 18
	% Households without a motor vehicle
	% Households without a telephone
	% Households with more than 1 person per room

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 53 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.

Comments/Responses: Most commenters were supportive and appreciative of the AIP option. A number of commenters weighed in on the \$250,000 upfront payment proposed, the amount of proposed quarterly payments, or total amount of advance investment payments generally. MedPAC urged CMS to adopt one of the alternatives described in the proposed rule—to calculate an ACO's average risk factors-based score and make the ACO's upfront \$250,000 payment contingent upon the ACO reaching a minimum average risk factors-based score (such as 25). Several commenters disagreed with the amount of AIPs proposed by CMS, for a variety of reasons, generally suggesting increases in the amount of AIPs. CMS disagrees with commenters' requests that it increase the amount of AIPs. With respect to MedPAC's suggestion to further limit payments if a new ACO's performance-based risk does not reach a minimum average risk factors-based score, CMS will continue to consider this approach and may revisit it in future rulemaking.

Commenters provided a variety of suggestions regarding the timing and periodicity of AIPs. CMS continues to believe that quarterly payments provide the best balance between consistent payments for ACOs and operational burden for CMS. CMS does not believe that allowing ACOs to have their quarterly payments calculated once at the beginning of the year, as opposed to at the beginning of each quarter, would offer significant benefit to ACOs nor substantially reduce burden for CMS. CMS states that fixing the quarterly payments at the beginning of a year creates unnecessary risk that quarterly payments are too high or too low relative to an ACO's assigned beneficiary population.

Several commenters were supportive of the use of risk factors-based scores and for particular elements of the proposed methodology to calculate those scores, including ADI, which CMS appreciated. Other commenters expressed concerns. MedPAC urged CMS to consider use of the Medicare Part D low-income subsidy (LIS) in the risk factors-based score rather than dual eligibility, citing recent Commission work that found using the LIS designation helped to reduce the impact of variation in state Medicaid benefits on nationally standardized Medicare policies. While CMS agrees that dual eligibility status has its limitations due to variability in Medicaid eligibility across states, LIS also has limitations, which CMS describes in the rule. For example, beneficiaries who do not have dual eligibility status or Supplemental Security Income (SSI) status but whose income is lower than 150 percent of the federal poverty level must apply for the LIS. Despite this limitation, CMS agrees that use of the LIS designation—in addition to dual eligibility status—is preferable to using dual eligibility status alone, as doing so reduces variability across states while moderately expanding the number of beneficiaries identified as low income and who will automatically qualify for the maximum risk factors-based score of 100.

CMS further notes that including LIS in the calculation provides ACOs with an incentive to support eligible beneficiaries who must apply for the benefit.

Several commenters also expressed concern regarding the application of the national ADI percentile ranks. For example, a couple commenters suggested that the measure is inadequate for identifying underserved populations, as the high cost of living for certain areas masks some disadvantaged areas, particularly high cost urban areas. Another commenter warned that relying heavily on ADI national percentile rankings may further disadvantage underserved populations in urban areas, given that the index is not adjusted for geographic differences in cost of living. A variety of alternatives were offered.

After consideration and review of commenters' suggestions, CMS believes that, at this time, the ADI national percentile rank remains the best available option for assigning a risk factors-based score to a beneficiary who does not have the LIS or dual eligibility designation. In the final rule, CMS provides additional justifications for its approach, along with acknowledgement of trade-offs regarding specific alternatives. CMS reiterated its appreciation for commenters' thoughtful input and intends to continue exploring how to incorporate such factors in a fair, standardized, comprehensive, and transparent manner into future policy.

Final Decision: CMS is finalizing its proposed policies with one modification, to incorporate the LIS designation in the calculation of the risk factors-based score at §425.630(f)(ii).

AIP Compliance and Monitoring. CMS proposed 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.

In the proposed rule, CMS expressed concern 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 expressed its intent to monitor ACOs that receive AIPs for changes in the risk experience of 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 proposed 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).

Comments/Responses: Several commenters requested CMS provide guidance on reporting requirements to minimize ACO administrative burden, which CMS said it will do. CMS reiterated that it will require an ACO to publicly report its spend plan in a standardized format before and after the performance year. Before each performance year, the ACO must publicly report the anticipated spend plan, including planned expenditure categories and percentages within each category. After each performance year, the ACO must publicly report the total amount of AIPs received and an itemization of the AIPs spent during the year, and any changes to the spend plan. CMS will also post information regarding the ACOs' AIP payments, spend plans, and actual expenditures on its Shared Savings Program data page.

Regarding remedial action if an ACO becomes designated as a high revenue ACO or an ACO experienced with performance-based risk, one commenter encouraged a more nuanced approach that considers the ACO's specific circumstance. For example, if an ACO adds a CAH to its ACO participant list and becomes high revenue, CMS could cease future payments of AIPs but not require payback, to avoid penalizing the ACO for adding a safety net provider. CMS disagrees but will employ a range of methods to monitor and assess the effectiveness of the AIP eligibility requirements as implemented.

Final Decision: CMS is finalizing its policies on proposed reporting, monitoring of ACO eligibility for AIPs, and termination of AIPs. The only modification from the proposal is to add language confirming that CMS may review eligibility during any performance year. Although this language was consistent with the preamble, CMS states it was inadvertently omitted from regulation text.

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 informed 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 proposed 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 contained details in the event of bankruptcy.

Comments/Responses: Several commenters suggested that CMS allow ACOs to retain some percentage of their shared savings payments during each recoupment period (e.g., up to 50 percent), which would make for longer recoupment periods. A few commenters believe longer recoupment periods would provide continuity and sustained funding, making these ACOs more likely to continue participation and to progress to more advanced levels of risk. CMS disagreed, citing that the policy as proposed safeguards the Medicare Trust Funds by recouping AIPs expeditiously. CMS does not believe immediately recouping the funds from earned shared savings will disadvantage any ACOs as they will be receiving quarterly payments for the first 2 years.

Commenters also suggested a variety of alternatives to further delay, forgive, or limit the amount of recoupment. On the other hand, MedPAC expressed concern that significant, forgivable upfront payments coupled with ACOs exiting the program would preclude program savings. Moreover, MedPAC asserted that several types of correction action would be necessary if program exits were high and significant upfront payments were not recouped, and that stringent requirements may be needed in the future to deter ACOs from receiving AIPs and then exiting the Shared Savings Program before they are paid back.

CMS disagreed that AIPs should not be recouped or should be recouped to a lesser degree under various circumstances. By requiring immediate repayment of AIPs upon early termination, CMS reduces the risk that ACOs will voluntarily terminate their participation agreements to avoid repayment of the AIPs. However, if an ACO terminates its agreement period early and fails to pay its AIP balance in full by the due date, CMS will charge interest on the remaining unpaid AIP balance. CMS thanked MedPAC for its concern for program oversight risks and pledged to

monitor the amount of AIPs that are not required to be repaid under the term of the program, which may be considered in future rulemaking.

Final Decision: CMS is finalizing the proposal on recoupment and recovery of AIPs without change.

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). 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 initiatives⁵ 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 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

⁵ Current regulations at §425.20 define “experienced with performance-based risk Medicare ACO initiatives” and “inexperienced with performance-based risk Medicare ACO initiatives.”

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 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, 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 54, reproduced below, shows that 59 percent of the 483 ACOs currently participating in the Shared Savings Program are in a two-sided model.

TABLE 54: 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 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.

CMS' stated goal is that 100 percent of people with Original Medicare will be in a care relationship with accountability for quality and total cost of care by 2030.⁶ The Shared Savings Program is the largest Medicare alternative payment model (APM) with 483 ACOs participating in PY 2022 and 11 million assigned beneficiaries. Thus, CMS emphasizes that the Shared Savings Program will play an important role in achieving the goal of creating care relationships with accountability for quality and costs for all Medicare FFS beneficiaries. CMS also believes that are well positioned to close gaps in health equity and that flexibility with respect to the timeline for progression to two-sided risk is important to encourage small, rural, safety-net providers to form ACOs or to join larger, more urban practices to share resources.

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 proposed 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 the policy as finalized.

⁶ Seshamani, M, Fowler E, and Brooks-LaSure C. "Building On The CMS Strategic Vision: Working Together For A Stronger Medicare." *Health Affairs* (January 11, 2022), <https://www.healthaffairs.org/doi/10.1377/forefront.20220110.198444>.

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

CMS proposed 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.⁷

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 proposed 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.

CMS proposed 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.

⁷ CMS notes this would not exclude re-entering former Track 1 ACOs.

CMS proposed 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 beginning January 1, 2023. In determining an ACO’s eligibility to participate under the new participation options, CMS proposed 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 proposed to make the ENHANCED track optional for all ACOs, regardless of experience with performance-based risk Medicare ACO initiatives, including high revenue ACOs.

CMS noted that the determination of whether an ACO is inexperienced or experienced with performance-based risk Medicare ACO initiatives could be affected by changes an ACO makes to its ACO participant list during the course of an agreement period. This is particularly the case for ACOs that are determined to be inexperienced when their agreement period begins but are close to the threshold percentage of 40 percent of ACO participants having participated in a performance-based risk Medicare ACO initiative in any of the 5 most recent performance years prior to the agreement start date. CMS noted concerns about the possibility that an ACO may begin in a one-sided level of the BASIC track based on being inexperienced, but then quickly seek to add ACO participants experienced with performance-based risk, thereby avoiding the limitations under the proposed participation options.

To protect against this circumstance, CMS proposed in §426.600(h) that it would monitor ACOs identified as inexperienced with performance-based risk Medicare ACO initiatives and participating in a one-sided BASIC track model for changes to their participant list that would cause them to be considered experienced that thus ineligible for participation in a one-sided model. CMS further proposed 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.

If an ACO meets the definition of experienced with performance-based risk Medicare ACO initiatives, CMS proposed that the ACO would be permitted to complete the remainder of its current performance year in a one-sided model of the BASIC track. However, it 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. In this case, the ACO would be automatically advanced to Level E of the BASIC track at the start of the next performance year. Table 55 of the rule illustrates with two hypothetical ACOs how CMS would monitor risk experience for agreement periods under Level A of the BASIC track.

Comments/Responses: Most commenters supported CMS’ proposal to allow ACOs inexperienced with performance-based risk to remain in Level A of the BASIC track during their first agreement period, emphasizing that the transition to performance-based risk under the current glide path can deter participation if ACOs are forced to assume risk too quickly. Many commenters praised the potential equity implications of the change, saying (among other things described in the rule) it would aid ACOs that incur higher costs when serving vulnerable populations and enable them to allocate funds to address SDOH. On the other hand, several

commenters argued that two-sided risk is necessary to drive reduction in spending and investments in transforming care delivery.

CMS agreed with the commenters, including the comments on two-sided risk. However, CMS also believes that allowing more time under a one-sided model will provide more ACOs with the time to make the needed preparations, such as adopting new technologies and processes to successfully take on two-sided risk while also achieving meaningful cost and quality improvements. CMS cites data showing that ACOs can take between 1-3 years to become accustomed to the Shared Savings Program and that ACOs are more likely to leave the program when they are unprepared to take on two-sided risk. Moreover, providers and suppliers that participate in a one-sided model are also able to realize shared savings while improving quality of care for patients.

One commenter expressed concern that the proposed changes could lead to those capable of moving to two-sided risk remaining in a one-sided model longer than necessary. On the other hand, others commented that the higher levels of risk in two-sided models are accompanied by higher levels of potential reward through higher available sharing rates. CMS agrees with the commenters who noted the significant financial incentives that encourage high-performing ACOs to continue forward along the glide path to risk. CMS believes that one-sided model participation provides incentives to manage total cost of care and make improvements in care quality while also providing stability, sustainability, and flexibility to those serving rural areas, safety-net providers, and providers in underserved areas.

MedPAC commented that an ACO should not be able to benefit from both 7 years under a one-sided model and a positive regional adjustment to its benchmark, since this could result in an ACO earning shared savings without making any demonstrable improvements in care delivery or cost reduction. MedPAC suggested that CMS consider implementing criteria that would assess if an ACO received a positive regional adjustment to its baseline expenditures when determining if an ACO is eligible for additional years in BASIC track Level A or Level B. CMS acknowledged MedPAC's concern but noted that such a restriction would largely moot the proposal, as around 90 percent of ACOs participating in the Shared Savings Program have received a positive regional adjustment in recent years.⁸ However, CMS appreciates MedPAC's concerns around potential ACO behavior during an extended period under a one-sided model, will continue to monitor ACO trends, and may take the suggestion into consideration in future rulemaking.

Commenters suggested a variety of adjustments to the proposal described in the rule. CMS responded that it believes its proposals strike an appropriate balance between allowing additional time in one-sided models and moving ACOs that begin to qualify as experienced with performance-based risk Medicare ACO initiatives to an appropriate level of two-sided risk.

⁸ CMS acknowledged this high percentage may be because of selective participation by ACOs that benefit from a positive regional adjustment, as their spending is already low compared to the region. However, CMS believes the proposal to allow extended participation in the one-sided model will appeal to those that would receive a negative regional adjustment and will increase their participation.

Final Decision: CMS finalizes without modification its proposal to permit some ACOs to remain in a one-sided model for an extended period of time.

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. CMS proposed 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 proposed that all ACOs would be permitted to participate indefinitely in the BASIC track Level E or the ENHANCED track.⁹

Table 56, reproduced below, summarizes the proposed participation option policies on which CMS sought comment and which were finalized here. As a guide to the table, "A, A, A, A, A" means that the entity can remain in Level A of the BASIC track for 5 years, and "A, B, C, D, E" means that the ACO has to progress annually through each level of the BASIC track as part of that ACO's glide path.

⁹ 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.

TABLE 56: Participation Options

ACO type	ACO experienced or inexperienced with performance-based risk Medicare ACO initiatives	Participation Options		
		First Agreement Period (or Subsequent for Renewing/Re-entering ACOs, or Current for Currently Participating ACOs)	Next Agreement Period	Future Agreement Periods
New legal entity (An ACO that has never participated in the Shared Savings Program and is not identified as a re- entering ACO or a renewing ACO)	Inexperienced*	A, A, A, A, A via one-time election prior to the start of the second performance year	A, B, C, D, E	Remain in Level E indefinitely, or move to ENHANCED track
New legal entity (An ACO that has never participated in the Shared Savings Program and is not identified as a re- entering ACO or a renewing ACO)	Experienced	E, E, E, E, E	E, E, E, E, E	Remain in Level E indefinitely, or move to ENHANCED track
Re-entering ACO	Inexperienced– former BASIC track Level A or B	A, B, C, D, E	E, E, E, E, E	Remain in Level E indefinitely, or move to ENHANCED track
Re-entering ACO	Inexperienced* – former Track 1	A, A, A, A, A via one-time election prior to the start of the second performance year	A, B, C, D, E	Remain in Level E indefinitely, or move to ENHANCED track
Re-entering ACO	Experienced– participated under Track 2, 3, BASIC track Level C, D, or E, ENHANCED track, the Track 1+ ACO Model, or another performance-based risk ACO initiative	E, E, E, E, E	E, E, E, E, E	Remain in Level E indefinitely, or move to ENHANCED track
Currently participating ACO in Level A or B for PY 2022	Inexperienced* – BASIC track Level A or B	Current level (remain at A or B for remainder of current agreement period)	A, B, C, D, E	Remain in Level E indefinitely, or move to ENHANCED track
ACOs in Level A or B with agreement periods beginning on January 1, 2023	Inexperienced* – BASIC track Level A or B	Current level (remain at A or B for remainder of current agreement period)	A, B, C, D, E	Remain in Level E indefinitely, or move to ENHANCED track
Renewing ACO	Inexperienced	A, B, C, D, E	E, E, E, E, E	Remain in Level E indefinitely, or move to ENHANCED track
Renewing ACO	Experienced– participated under Track 2, 3, BASIC track Level C, D, or E, or ENHANCED track, the Track 1+ ACO Model, or another performance-based risk ACO initiative	E, E, E, E, E	E, E, E, E, E	Remain in Level E indefinitely, or move to ENHANCED track

Note: Any ACO, regardless of type or experience level, may elect to progress more quickly along the BASIC track glide path or to apply to enter a new agreement period under the ENHANCED track at any time.

* Under §425.600(h), if an inexperienced ACO meets the definition of experienced with performance-based risk Medicare ACO initiatives (as specified in § 425.20), that 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 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.

Comments/Responses: All comments received that included mention of CMS' proposal to allow ACOs to remain in Level E of the BASIC track indefinitely and elect to not move to the ENHANCED track were supportive.

Final Decision: CMS is finalizing the policy as proposed.

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). The complete list of codes to be used for Shared Savings Program assignment purposes beginning with PY 2023 is provided below.

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

CMS finalizes its proposal to add 4 services to the list of primary care services used for assignment of beneficiaries to Shared Savings Program ACOs for performance year 2023 and subsequent years. These HCPCS G-codes were finalized for payment under the PFS as discussed earlier in this rule (see section II.F for G3017 and G3018 and II.E for G3002 and G3003).

(1) Prolonged Services G0317 (proposed as GXXX2) and G0318 (proposed as GXXX3)

- G0317 Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service, each additional 15 minutes

This code is 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.

- G0318 Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service, each additional 15 minutes

This code is added to an initial or subsequent home or residence visit (CPT codes 99345 and 99350, respectively) for each 15-minute increment beyond the total time of the primary service.

(2) Chronic Pain Management Services G3002 and G3003 (proposed as GYYY1 and GYYY2, respectively)

- G3002 Chronic pain management and treatment, monthly bundle, first 30 minutes personally provided by physician or other qualified health professional, per calendar month
- G3003 Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health professional, per calendar month

This code is added to G3002 for each 15-minute increment per calendar month once the time spent by the physician or NPP exceeds the first 30 minutes for the calendar month.

Many commenters supported the addition of G0317, G0318, G3002, and G3003 to the list of primary care services used for Shared Savings Program beneficiary assignment. A few opposed the addition of chronic pain management services G3002 and G3003 as inconsistent with the intended meaning of primary care services under the Program.

CMS views the addition of G0317 and G0318 to the primary care services list as appropriate because both are add-on codes to base codes already appearing on the list. CMS further states that adding the chronic pain management codes G3002 and G3003 is appropriate because these services share many elements with chronic care management and principal care management services (CPT codes 99430 and 99425, respectively) that are codes already included on the list. CMS will monitor utilization of G3002 and G3003 to confirm that these services are predominately furnished by primary care practitioners.

(3) Primary Care Service Codes for Shared Savings Program Beneficiary Assignment for Performance Year 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 and G2252 (virtual check-in).
- G2058 (non-complex chronic care management).
- G2064 and G2065 (principal care management services).
- G2212, G0317, and G0318 (prolonged office or other outpatient evaluation and management services)
- G2214 (Psychiatric collaborative care model).
- G3002 and G3003 (chronic pain management services).

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

CMS finalizes the incorporation of 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. To implement the update, CMS will add a revised list of primary care services at §425.400(c)(1)(vii) for performance year 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.¹⁰ Conforming changes are finalized at §425.400(c)(1)(vi) for performance year 2022.

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

CMS finalizes as proposed revisions to the process whereby certain facilities are identified for use in beneficiary assignment, including when a facility’s CCN enrollment changes during a

¹⁰ 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.”

Shared Savings Program performance year. The revised process will 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 is 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 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.

Comments received were few but supportive. CMS believes the revised process will more accurately capture changes to providers and suppliers that participate in an ACO for a given performance year.

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).¹¹ Beginning with PY 2025, only the APP reporting mechanism will be available.

¹¹ 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.

In this rule, CMS finalizes as proposed adding an alternative quality performance standard, basing shared savings and loss amounts on sliding scales, and extending the transition period's existing incentive for reporting the APP measures. CMS finalizes with a formula modification its proposal to implement a health equity adjustment to ACO quality scores based on dual eligibility, residence in a disadvantaged neighborhood, and Part D low income subsidy (LIS) enrollment. Minor changes are finalized as proposed for Web Interface and APP measures. No changes were 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 clarifies its process for reopening ACO financial performance determinations when quality score errors are subsequently discovered through MIPS targeted reviews. Finally, CMS reviews its 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 finalizes as proposed the adoption of a new “alternative” quality performance standard beginning with PY 2023 for the purpose of applying sliding scales to shared savings and losses. 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.

Commenters were supportive of the alternative standard and its purpose. A suggestion to limit applicability of the standard to a maximum of 3 PYs per ACO to ensure overall Shared Savings Program quality was rejected by CMS as unnecessary.

The existing quality standard as finalized during CY 2022 rulemaking will be retained, with modification to incorporate the health equity adjusted score finalized later in the rule and described later in this summary. The requirement to field the CAHPS for MIPS survey applies to both quality standards. CMS will continue to calculate results for two claims-based measures as part of both standards.

Finalized performance parameters of the two standards and their associated reporting requirements are shown in Table 61 of the rule (reproduced below with minor format changes). A narrative summary of the finalized quality performance standards organized by applicable performance year is provided in section III.G.4.b.(9) of the rule. The final CMS Web Interface measures are found in Table 62; this reporting option will no longer be available starting with PY 2025. The final APP measure set for PY 2023 and subsequent years is provided in Table 63 of the rule and reproduced below.

Table 61. Final APP Reporting Requirements and Quality Reporting Standard for PY 2023 and Subsequent PYs			
	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 survey. CMS calculates 2 claims-based measures.	Same as PY 2023	Report the 3 APP eCQMs/MIPS CQMs; and administer CAHPS for MIPS 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 \geq 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 \geq 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 \geq 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 allows receipt of 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 allows receipt of 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. Not eligible for shared savings.	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. Not eligible for shared savings.
*Facility-based scoring allows certain clinicians (e.g., pathologists) to be scored using their facilities' Hospital Value Based Purchasing Program results.			

Table 63: 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			

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

Beginning with PY 2023, CMS finalizes as proposed the adoption of a sliding scale approach to calculate shared savings for certain BASIC and ENHANCED track ACOs according to the formula below. An example calculation is described in section III.G.4.b.(2) of the rule.

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

The sliding scale is applicable to ACOs that meet the alternative quality performance standard but not the existing standard. Sliding scale eligibility is not affected by ACO reporting mechanism (CMS Web Interface or APP). ACOs that meet the existing standard will continue to be eligible for shared savings at the maximum rate for their track and level. An ACO that meets neither the existing or alternative standard would be ineligible for shared savings.

Commenters were supportive. Some offered suggestions on topics that CMS categorizes as out of scope of this rule (e.g., the scheduled sunseting of the CMS Web Interface reporting mechanism at the end of CY 2024).

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. Later in this rule CMS finalizes criteria at §425.605(h) allowing certain low-revenue ACOs in the BASIC track to share in savings even if the ACO does not meet its MSR beginning with PY 2024. An ACO that satisfies the specified criteria and meets the existing quality reporting standard will be eligible to receive shared savings at one-half of the maximum sharing rate for their track and level. The reader is referred to section III.G.5. of the rule and to the Financial Methodology section of this summary below for further discussion.

c. Scaled Shared Losses (§425.610)

CMS finalizes as proposed the adoption of a sliding scale approach to calculate shared losses for ENHANCED track ACOs according to the formula below.¹² The shared loss rate is subject to a minimum of 40 percent and a maximum of 75 percent. An example calculation is described in section III.G.4.b.(3) of the rule.

$$\text{Scaled shared loss rate} = 1 - (\text{health-equity adjusted quality score} \times 75\%)$$

The sliding scale is applicable to ACOs that meet either the alternative or existing quality performance standard. Sliding scale eligibility is not affected by ACO reporting mechanism (CMS Web Interface or APP). An ACO that meets neither standard is subject to the maximum loss rate of 75 percent.

Commenters were supportive, viewing the sliding scale loss rates as a more balanced approach.

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

In the proposed rule, CMS described a potential conflict between the proposed ACO alternative quality standard and the existing criteria for determining Advanced APM status. Elsewhere in this final rule (section IV.A.4.a.) CMS eliminates the potential conflict by finalizing a modified Advanced APM quality criterion, allowing the criterion to be met by a single measure that is an outcome measure. Harmonizing the newly finalized alternative quality standard with the newly finalized Advanced APM criterion allows BASIC Level E and ENHANCED track ACOs to retain their designations as Advanced APMs and their providers to remain eligible to reach APM Qualifying Participant (QP) status and receive QP-associated financial incentives.

e. Extension of eCQM/MIPS CQM Transition Incentive

CMS finalizes its proposal 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 through PY 2024. The incentive 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 40th percentile on one or more of the remaining APP measures.

Commenters were supportive. Some requested extension of the incentive beyond 2024 to encourage ACOs to further increase their reporting of eCQMs. Others suggested direct financial incentives be offered for transitioning to eCQM reporting. Clarification was requested about whether ACO Entities that are Federally Qualified Health Centers (FQHCs) must report MIPS CQMs beginning in PY 2025 since FQHCs are exempt from MIPS reporting.

¹² CMS also modifies the shared loss rate by substituting “health-equity adjusted quality performance score” for predecessor language “the quotient of the MIPS quality performance category points earned divided by the total MIPS quality performance category points available”. The variables described by the two phrases are the same.

CMS declines to extend the transition incentive and to make direct incentive payments to ACOs and enumerates the initiatives already underway to assist ACOs in reporting MIPS CQMs and eCQMs. The agency clarifies that FQHC-ACOs are being required to report quality data using measures taken from the MIPS inventory but are not being required to participate in MIPS. CMS notes that other commenters raised topics that are out of scope for this rule (e.g., requiring quality data submission for all patients regardless of payer).

f. Health Equity Adjustment

CMS finalizes adoption of a health equity adjustment into the Shared Savings Program beginning with PY 2023. The adjustment will be applied in the form of bonus points added to each ACO's MIPS Quality performance category score to generate its health equity adjusted quality performance score and be available only to ACOs who report quality data via the APP. The adjusted score will be used to determine whether the existing quality standard has been met, to calculate scaled shared savings and shared loss rates, and to compute quality scores under the Program's extreme and uncontrollable circumstances policy.

Numerous commenters supported the concept of a health equity adjustment and its application to the Shared Savings Program but many also asserted that the adjustment should be available to all ACOs not just those reporting quality data through the APP. Some agreed that a direct scoring adjustment was a preferable approach for achieving equity over extensive risk adjustment of quality measures as the latter carries the risk of masking disparities. Others recommended a pilot test of the equity adjustment before full implementation. Concern was raised that the equity adjustment was too small to be impactful.

CMS disagrees with all of the commenters' suggestions for modifying the health equity adjustment, believing it to be appropriately targeted to aid ACOs with larger numbers of disadvantaged beneficiaries and of sufficient magnitude to be impactful.

(1) Performance Grouping and Measure Performance Scaler

CMS finalizes as proposed the methodology for a measure performance scaler to be used in computing the health-equity adjusted quality score. Example calculations are described in section III.G.4.b(7)(f) and Table 57 of the rule.

Based on their performances for the 6 APP measures ACOs will be divided into thirds, creating top, middle, and bottom "performance groups" for each measure. Comparisons also will account for reporting mechanism: ACOs reporting eCQMs will be grouped only with other eCQM reporters while ACOs reporting MIPS CQMs will be grouped only with other MIPS CQM reporters. Comparisons for CAHPS and claims-based measures will group all ACOs submitting data for these measures together as all ACOs report through the same mechanism.

CMS will assign values for each of the 6 measures for each ACO: 4 points for top performers, 2 for middle performers, and zero for bottom performers. The values are summed to create a "measure performance scaler", ranging from 0 to 24 points. A value of zero is assigned for a

measure whose case minimum or sample size is not met by an ACO. CMS will calculate a measure performance scaler for any ACO that submits complete data for at least 3 of the eCQM/MIPS CQM measures.

Commenters expressed reservations about the measure performance scaler methodology, stating that the scaler does not properly target ACOs treating large numbers of disadvantaged beneficiaries. Some were concerned that creating multiple performance groups (three tiers, subdivided by reporting mechanism) would introduce statistical issues related to small numbers. Others found the methodology to be too complex and suggested substituting the ACO Quality category performance score.

CMS disagrees with the commenters. The goal of the performance scaler is to identify high performing ACOs by taking into account performance on all measures using performance-based peer group comparisons. CMS states that an ACO seldom performs equally well or poorly across the APP measures and has observed this variation for ACOs regardless of their shares of disadvantaged beneficiaries. CMS intends for the equity adjustment to support ACOs with large shares of disadvantaged beneficiaries but that also deliver high quality care, and the performance scaler purposefully reflects quality performance. Targeting the equity adjustment is accomplished by other components of the equity adjustment bonus described later in the rule and in this summary (e.g., the underserved multiplier). CMS acknowledges the potential for small numbers issues but states this will resolve as the number of ACOs reporting through the APP mechanism increases. CMS views the methodology's complexity to be sufficient to achieve the goal of the performance scaler without being excessive.

(2) Underserved Multiplier: Design Components

CMS finalizes adding enrollment in the Part D low income subsidy (LIS) as a third criterion for identifying ACOs with high shares of disadvantaged beneficiaries to the proposed two criteria of dual eligibility status and census block-level area deprivation index (ADI). CMS finalizes that the criterion for which an ACO has the highest value based on its assigned beneficiary population will be used in determining its multiplier: proportion of dually eligible beneficiaries, proportion residing in neighborhoods with ADI national percentile ranks of 85 or higher, or proportion that are enrolled in the LIS. Multiplier values will range between 0 and 1. Both the underserved multiplier and the measure performance scaler will be used in calculating an ACO's health equity adjustment.

Many commenters supported the concept of an underserved multiplier and the two criteria proposed for its application. Many also supported adding LIS enrollment as a third criterion. Some supported using other criteria or combinations of criteria. Numerous commenters voiced reservations about use of the ADI as a criterion including: ADI overweighs area income and home values versus other area indicators of disadvantage; ADI underestimates vulnerabilities of neighborhoods with the highest chronic disease burdens and lowest life expectancies; and correlations between ADI and health outcomes are greatest when local rather than national rank values are used.

CMS cites a recent environmental scan conducted by the Assistant Secretary for Planning and Evaluation (ASPE) in which none of the existing area-level indices of disadvantage were found to be ideal.¹³ The ASPE report concluded that the ADI and the Social Deprivation Index were the best options available immediately for use in policy development to address health related social needs or social determinants of health. CMS views its three underserved multiplier eligibility criteria as being complementary, noting that the LIS is standardized nationally, dual eligibility varies across states, and the ADI reflects all-payer populations rather than solely Medicare beneficiaries. CMS anticipates that when used together the criteria will allow appropriate identification of ACOs to whom the equity adjustment should be targeted while use of the single highest criterion value for the multiplier will limit double counting of beneficiaries that satisfy multiple criteria.

(3) Underserved Multiplier and Bonus Points: Floor and Limits

CMS finalizes as proposed:

- 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,
- to cap the health-equity adjustment bonus points at 10, and
- to cap the health-equity adjusted quality performance score at 100 percent.

A few commenters were supportive and many voiced concerns. Several commenters recommended eliminating the multiplier floor, terming it arbitrary and discouraging to ACOs considering expansion of their underserved populations. Others disagreed with capping the bonus points at 10 as an insufficient incentive for ACOs to invest in expanding their disadvantaged patient population and suggested other incentives such as benchmark bonuses. Several recommended delaying equity adjustment implementation until all ACOs are prepared to report through the APP.

CMS declines to adjust the multiplier floor, citing an internal analysis showing that about 34 percent of ACOs would have multipliers above the 20 percent floor based on PY 2021 data. CMS also declines to change the 10-point bonus cap, stating that the equity adjustment is designed to strike a balance between incentivizing ACO reporting of eCQM/MIPS CQM measures, rewarding high quality ACOs that serve larger proportions of underserved beneficiaries, and avoiding overly inflating an ACO's quality performance score. CMS rejects delayed implementation as inconsistent with the agency's goal to support ACOs during their transitions to the APP's all-payer eCQM/MIPS CQM measures. Based on PY 2021 data, CMS notes that at least one ACO already reporting via the APP would have received the maximum 10-point adjustment.

¹³ Landscape of Area-Level Deprivation Measures and Other Approaches to Account for Social Risk and Social Determinants of Health in Health Care Payments. September 26, 2022. <https://aspe.hhs.gov/reports/area-level-measures-account-sdoh>.

(4) Calculation Steps and Examples

In section III.G.4.b(7)(f) of the rule CMS reviews the finalized series of calculations that will be followed 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. Health-equity bonus points = MIPS Quality performance category score x measure performance scaler x underserved multiplier = step 1 result multiplied by step 2 result. ACO #3 is awarded 5.4 bonus points (18 x 0.3).

Step 4: Calculate the equity-adjusted performance score. Health-equity adjusted quality performance score = MIPS Quality performance category score + health-equity adjustment bonus points (result from step 3). 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.

CMS received no comments specifically about the calculation steps or examples. Later in the preamble 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).

(5) Equity Adjustment Reports for ACOs

CMS finalizes as proposed adding information on health equity adjustment calculations to existing reconciliation reports for those ACOs who report quality data through the APP mechanism.

Commenters requested additional information including geographic distributions within their ACO populations for dual status, LIS enrollment and ADI national rank. Others requested that CMS provide quality performance data stratified for race and ethnicity as well as for dual status, LIS enrollment and ADI national rank.

CMS responds that HIPAA-compliant data-sharing will be available under the agency's existing data-sharing regulations. Planned data-sharing will include beneficiary-identifiable data for dual eligibility, LIS enrollment, and ADI national rank on a quarterly basis and annually to support care coordination and quality improvement efforts. CMS will take under consideration additional information requested by commenters.

(6) Miscellaneous Comments, Final Proposals, and Regulation Text Changes

In section III.G.4.b.7(h) CMS acknowledges other comments received not already discussed in the preamble. These include recommendations that CMS (1) provide incentives for consistent collection of data that can better identify disparities, such as reimbursement for reporting social risk factor screening and ICD-10-CM z-codes, and (2) explore ways to explicitly include community organizations within a "broadened ACO structure". CMS notes that some miscellaneous recommendations by commenters fell outside of the scope for this rule but states that all may be considered during future rulemaking.

In section III.G.4.b.7(h), CMS provides a narrative summary of the proposals being finalized related to creating and implementing a health equity adjustment for the Shared Savings Program in the order they appear in the rule. Also in this section CMS provides a narrative summary of the regulation text changes corresponding to the finalized health equity adjustment proposals.

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

CMS finalizes as proposed specifying that the health equity-adjusted quality performance score will be used 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 (EUC).

Substituting the equity-adjusted score for the unadjusted score, however, has limited impact because the EUC 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 and 40th percentile for subsequent PYs).

CMS received no comments on its EUC policy proposals. CMS provides additional clarifications about the interactions between the EUC and bonus point policies as follows:

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

- Bonus points will be calculated and awarded as finalized in this rule for an affected ACO that meets eligibility criteria to receive a health equity adjustment as finalized in this rule. If the equity-adjusted quality score is higher than the quality performance score assigned to the ACO per existing EUC policy, the equity-adjusted score will replace the policy-based score. In practicality, the ACO will 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. In that case, the higher (equity-adjusted) score will be used to calculate the shared loss reductions.
- An ACO affected by EUC that fails to report quality data via the APP, or whose data do not meet completeness or case minimum requirements, by definition is not eligible to receive equity bonus points. Therefore, the affected ACO will be assigned its quality score per policy (e.g., 30th percentile across MIPS quality measures for PY 2023).

g. Shared Savings Program Quality Measure and Benchmark Changes

(1) Web Interface Reporting

CMS notes that measure Q110 *Preventive Care and Screening: Influenza Immunization* is being finalized for removal from the MIPS Quality Measure Inventory for traditional MIPS but is retained for use as a Shared Savings Program Web Interface measure (see Appendix 1 Table Group CC Item CC.1 for a detailed rationale). Changes proposed to all 10 Web Interface measures that revise technical specifications or increase alignment between eCQMs and their corresponding MIPS CQMs are finalized without modification. All of the measures, the changes, and rationales for change are described in detail in Appendix 1 Table Group E.

(2) Web Interface Benchmarks

Setting Benchmarks for PYs 2022 through 2024

CMS finalizes its proposal 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 by adding new paragraph (a)(6) to §425.512.

When use of the Web Interface measure set by ACOs was extended beyond PY 2021 during CY 2022 PFS rulemaking, CMS inadvertently failed to update the measure benchmarks. Setting benchmarks in this final rule for PY 2022 represents retroactive application of a substantive change and CMS does 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.

Using Flat Percentage Benchmarks for PY 2022

CMS also finalizes as proposed scoring 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 (i.e., the measure would be pay-for-reporting) 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 again applies its section 1871(e)(1)(A) authority to make these retroactive substantive changes, asserting that the best interests of the public are being served since the availability of more measures for scoring could increase shared savings opportunities for ACOs. CMS anticipates applying flat percentage benchmarks again for PY 2023 for these 2 measures.

Commenters objected to setting flat performance benchmarks for Q226 and Q134 and the resulting retroactive increase in the number of scored Web Interface measures. CMS acknowledges the objections but reiterates that the benchmark changes are intended to address inadvertent errors by the agency and are in the public interest as is required under section 1871(e)(1)(A) of the Act whenever the agency applies substantive changes retroactively.

(3) APP Measure Reporting

CMS finalizes its proposal to retitle the measure *Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS* as previously 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 beginning with PY 2023.

No comments were received. CMS notes the change aligns measure nomenclature between the Shared Savings Program and the MIPS Quality Inventory.

h. 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 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 PYs 2020 and 2021, reproduced below with the addition of the erroneously calculated, previously published values.

Commenters requested clarification of the meanings of *unweighted* and *weighted* score distributions. CMS explains that the weighted distribution applies to individual providers during MIPS final payment calculations while the unweighted distribution is based on scores of a submitting entity (e.g., ACO) rather than scores of individuals. CMS states that the two distributions differ only in the number of data points observed with a given score.

Table 54: Historical Unweighted MIPS Quality Performance Category Scores (modified by HPA to include previously published incorrect 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
2021	*No value published	61.73	*No value published	77.83
*Incorrect values were not published for these performance years. The correct values are provided as additional reference points.				

i. Reopening Initial Determinations of ACO Financial Performance

CMS requested comment on its planned approach for using its discretion to reopen its initial or final ACO financial performance determination when 1) after a determination has been made, CMS learns that corrections to the ACO's MIPS Quality performance category score are necessary, and 2) the corrections could impact the ACO's shared savings eligibility or the amount of its shared savings/losses. According to the agency's planned 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 a shared savings eligibility determination or shared savings/loss amounts;
- 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; and
- 4) 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.

CMS explains that the need for reopening can arise because 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, such 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.

Most commenters urged CMS to reconsider its planned approach to reopening. Significant concern was expressed that expecting ACOs to return shared savings or pay additional shared losses to CMS based on errors identified on a delayed basis after reconciliation reports were issued is unreasonable and impractical, particularly when monies for return to CMS would need to be clawed back from ACO providers and suppliers. Commenters stated this reopening approach will discourage new or continued participation by ACOs in the Shared Savings Program. Some commenters strongly recommended that CMS set a limit on the time period that can pass between retroactive reopening and the initial ACO financial performance determination and suggested 12 months. Others asserted that either more alignment is needed immediately between MIPS and the Shared Savings Program processes or the link between the two for scoring purposes should be eliminated.

CMS disagrees with commenters and views its planned approach as striking an appropriate balance between important Medicare program integrity concerns about timely, accurate Shared Savings Program payments and minimizing unnecessary operational burdens for ACOs. CMS plans to work with the Quality Payment Program staff on ways to allow earlier identification of potential MIPS errors that could affect ACOs. CMS also notes that a time limit on reopening already exists of no later than 4 years after the initial notice to an ACO of its savings/loss determination (§425.315).

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

In the proposed rule, CMS requested input on the potential future inclusion of two new measures in the APP Measure set for use in the Shared Savings Program 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 finalized elsewhere in this rule for inclusion within all of the specialty measure sets of the MIPS quality performance measure inventory 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 finalized 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 has not been proposed for addition to the MIPS quality measure inventory. It has been specified as a CQM but not as an eCQM. 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 finalized 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.

Specific questions posed by CMS about the two Social Drivers of Health measures are listed in section III.G.4.f. of the rule. CMS indicates having received comments about both measures but does not provide any details, stating only that the feedback received may be considered during future rulemaking.

Comments about adding the measure *Screening for Social Drivers of Health* to the traditional MIPS quality measure inventory were numerous and detailed and the reader is referred to Appendix 1 Table Group A Item A.3 for that discussion. Comments were received in support of and in opposition to adding the measure. As finalized it is not a required measure but will be available for self-selection by MIPS eligible clinicians for reporting through traditional MIPS.

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

In the proposed rule CMS posed 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 asked for input on adding the question and response choices below to the CAHPS for MIPS survey. This question is being tested in the Medicare Advantage program.

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.

Price Transparency

The CAHPS for MIPS 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 requested feedback about 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 requested 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.

CMS indicates that feedback was received concerning adding questions addressing the topics listed above to the CAHPS for MIPS survey but offers no details, stating only that the feedback received may be considered during future rulemaking.

5. Financial Methodology

a. Overview

In this section of the final rule, CMS finalizes modifications to the financial methodologies under the Shared Savings Program. It states that its policies 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 finalizes its proposals 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 final rule also discusses alternatives to some of the combinations it finalizes. It discusses ongoing concerns about the impact of the PHE for COVID-19 on ACOs’ expenditures. It also finalizes its proposal to exclude a new supplemental payment for Indian Health Service and 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. It concludes with a discussion of modifications to 42 CFR part 425, subpart G to incorporate the related policy changes.

Within this section of this final rule CMS summarizes and responds to public comments on these topics. It also responds to some overarching issues that are summarized below.

Some commenters expressed concern that several of the proposed changes to the financial methodology would only go into effect for ACOs entering a new agreement period in 2024 or a subsequent year. Many of these commenters suggested that CMS allow ACOs the option of opting into the proposed changes without having to complete the early renewal process or wait until they enter a new agreement period. CMS also received a comment that expressed concern over the Shared Savings Program becoming increasingly complex and changing frequently. The commenter expressed concern that this could create a barrier to participation in the Shared Savings Program as sophisticated modeling is necessary to determine if an ACO has a chance for success in the program.

CMS disagrees and states that ACOs will be subject to the changes it is finalizing to the Shared Savings Program's financial methodology on an agreement period basis, unless specified otherwise. It believes the timing of applicability for the benchmarking changes will allow sufficient time for current ACOs to decide whether to renew for a new agreement period under the Shared Savings Program, for providers/suppliers to consider the business case for forming or joining a Shared Savings Program ACO, and for CMS to prepare to implement these changes. CMS is also concerned that such flexibility could lead to opportunities for arbitrage and may dull incentives for ACOs to improve their performance under the Shared Savings Program. Further, doing so would introduce considerable operational complexity into the program's benchmarking methodology.

In response to the commenters' concern about complexity, CMS states it does not believe that the changes to the financial methodology it is finalizing in this final rule create additional complexity that will create barriers to participation in the Shared Savings Program. It also remains committed to its specifications documents, programmatic resources, and other materials to support ACOs in understanding the financial methodology that is applicable to their agreement period, and to provide ACOs with aggregate reports and beneficiary-identifiable claims data.

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

¹⁴ See [Shared Savings and Losses and Assignment Methodology Specifications Version 10 \(cms.gov\)](https://www.cms.gov/medicare/medicare-coverage-database/details/2021-pfs-final-rule)

- 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 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 Savings 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 involved 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 finalizes a combination of policies to its benchmarking methodology intended to reduce the effect of ACO performance on ACO historical benchmarks and increase options for ACOs caring for high-risk populations. Specifically, CMS finalizes its proposal 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 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 changes 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.

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

i. Policy Description

CMS finalizes its proposal to incorporate a prospectively projected administrative growth factor, a variant of the United States Per Capita Cost (USPCC) referred to in the final 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 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.

CMS will 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 BY3 and the PY. The CMS Office of the Actuary (OACT) will project the ACPT, which 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, uncompensated care 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. CMS will 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.

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. CMS will risk adjust the flat dollar amounts 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. The ACPT flat dollar amounts will not be adjusted 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 final rule the four steps it will use to set the annualized growth rate(s) and calculate the ACPT flat dollar amount(s) included in the three-way blend.

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

For step 1, OACT will 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 rates 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 will 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 \times (1.050 - 1) = \650 , and PY5 flat dollar amount = $\$13,000 \times (1.276 - 1) = \$3,588$

Step 3: Risk adjust the flat dollar amounts.

In step 3, CMS will 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 will 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 will 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 \times 1.025 = \666 , and PY5 flat dollar amount = $\$3,588 \times 1.025 = \$3,678$

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 will 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 will 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 will then be combined with the two-way blend to compute the three-way blended update factor. The ACPT will constitute one-third of the total blend, while the remaining two-thirds will 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 finalizes 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 will 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 will 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 will 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). CMS will 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.

ii. Discussion of Comments

Many commenters generally supported an approach under which CMS would prospectively set a component of the ACO’s updated historical benchmarks, with many supporting the proposed approach to use a three-way blended update factor. They believed that it would provide greater stability to the benchmark value and allow ACOs to better predict their benchmarks and have greater visibility into the benchmark calculation. In addition, they believed it could offset regional factors that make it difficult for ACOs to achieve shared savings and serve to disincentivize ACOs from providing care to certain beneficiary populations.

More generally, some commenters believed that use of a prospective, external factor in the benchmarking methodology would be a step toward a longer-term administrative benchmarking approach. They believed that the ratchet effect and CMS’ goal of having all Medicare FFS beneficiaries in an accountable care arrangement by 2030 make the current benchmarking strategies untenable. These commenters explained that the ACPT would serve as a positive short-term step to ameliorating these issues while CMS works to refine its administrative benchmarking strategy.

A few commenters urged CMS not to finalize use of a prospective, external factor in updating ACO historical benchmarks. They urged CMS to take additional time to evaluate or pilot test the potential impact of the proposed approach before full implementation. Some provided alternative suggestions for modifying the benchmarking methodology. Commenters' concerns tended to center on the unknown accuracy of the projected amount, the potential for mixed effects of the approach under which ACOs may receive lower benchmarks under the three-way blend compared to the existing two-way blend, and a preference among some commenters for use of regional FFS trends in benchmark calculations. Additional details on these concerns can be found in the final rule.

CMS declines commenters' suggestions and finalizes its proposal to apply this approach to update ACO benchmarks for agreement periods beginning on January 1, 2024, and in subsequent years. It believes the three-way blended update factor is one of several timely and appropriate changes to the Shared Savings Program's benchmarking methodology designed to ensure the availability of robust benchmarks that create sufficient incentives to encourage ACOs to enter and remain in the program. Further, CMS states that finalizing the three-way blended update factor in this final rule, as part of a package of benchmark changes, is crucial to supporting the agency's goal of having all Medicare FFS beneficiaries in an accountable care arrangement by 2030.

After consideration of the public comments, CMS finalizes without modification its proposal to update an ACO's historical benchmark based on a three-way blend of the ACPT and blended national-regional growth rates, for agreement periods beginning on January 1, 2024, and in subsequent years. It also finalizes, as proposed, the modifications to its regulations to incorporate the use of the three-way blend. The use of the three-way blend, the associated guardrail, and the discretion for CMS to adjust the weight of the ACPT in the three-way blend in the event of unforeseen circumstances are specified in paragraph (b) of a new provision at §425.652, which would govern the process for establishing, adjusting, and updating the benchmark for agreement periods beginning on January 1, 2024, and in subsequent years. It also specifies within §425.652(b) the other components of the update factor, namely the calculation of the national and regional components of the blend, which follows the same approach specified under §425.601(b), with conforming changes to reflect the use within a three-way blend. Further, it specifies the calculation of the ACPT in a new provision at §425.660. CMS states that will evaluate and monitor the impact of the ACPT on ACO historical benchmarks, and would address any necessary refinements to the approach through future notice and comment rulemaking.

(4) Adjusting ACO Benchmarks to Account for Prior Savings

CMS finalizes its 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. 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 will adjust an ACO's benchmark based on the higher of either the prior

savings adjustment or the ACO's positive regional adjustment. It will 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 policy will help ensure that high performing ACOs have incentives to remain in the program for the long-term.

CMS will 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 will 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 will 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 will 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 will not be eligible for a prior savings adjustment. The ACO will receive the regional adjustment to its benchmark.
- If the average per capita value is positive, the ACO will be eligible for a prior savings adjustment.

Step 3: Apply a proration factor to the per capita savings calculated in Step 2. This will 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 will 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 final rule, CMS will adjust an ACO's benchmark based on the higher of either the prior savings adjustment or the ACO's positive regional adjustment. It will also use a prior savings adjustment to offset negative regional adjustments for ACOs that are higher spending compared to their regional service area.

Tables 65 through 68 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 ACO 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 sought comment on its proposal to adjust the ACO's historical benchmark for savings generated in the ACO's prior agreement period.

Commenters generally supported CMS' proposal to adjust ACO benchmarks for prior savings, although some commenters described certain concerns about or suggested modifications to the calculation methodology. Many commenters offered a variety of suggestions to broaden the policy's impact to make it more favorable to ACOs. These suggestions included making the scaling factor used to calculate the adjustment more generous, applying the average savings rate from an ACO's prior agreement period as an upward adjustment to the historical benchmark, increasing the cap on the prior savings adjustment, and including savings earned in other alternative payment models in the calculation of the prior savings adjustment. Several commenters suggested that CMS modify the cap on the prior savings adjustment, which was proposed to be set at 5 percent. Several commenters suggested that CMS should make this methodology change available to all ACOs in existing agreement periods beginning in PY 2024. MedPAC also raised several concerns about implementing proposals designed to combat ratcheting effects—specifically the prior savings adjustment and the ACPT—alongside the regional adjustment. It urged CMS to use the prior savings adjustment as a means of phasing out the regional adjustment given their criticism that the regional adjustments have generated “illusory savings.”

CMS agrees with the overall support and states its proposed approach strikes an appropriate balance by mitigating the rebasing ratchet effect on an ACO's benchmark through returning to an ACO's benchmark an amount that reflects its success in lowering growth in expenditures while safeguarding the Medicare Trust Funds from excessive shared savings payments that could result from overly inflated benchmarks. CMS declines to adopt commenters' suggestions for modifying the cap on the prior savings adjustment to make it more generous to ACOs, or for a subset of ACOs including ACOs serving a high proportion of high risk or medically complex beneficiaries, either through risk adjustment or other methods. It states that the cap is set at a reasonable level and that based on its modeling less than 5 percent of ACOs receiving the prior savings adjustment would be impacted by the cap on the prior savings adjustment. It also does not believe it would be appropriate to institute the prior savings adjustment available to all ACOs in existing agreement periods beginning in PY 2024 until they enter a new agreement period because doing so would disrupt the consistency of an ACO's benchmarking methodology within a single agreement period. CMS also disagrees with MedPAC and notes that the interactions between the ACPT, the prior savings adjustment, and the regional adjustment are designed more broadly to address different dynamics within the benchmark. CMS states, however, that it intends to monitor the collective impacts of these approaches on ACO benchmarks for evidence of over-inflation or negative impacts to the Trust Fund. It may address these issues in future rulemaking if necessary.

CMS finalizes as proposed the methodology for instituting a prior savings adjustment. This new policy will be specified in a new provision at §425.658 applicable for agreement periods beginning on January 1, 2024, and in subsequent years. This provision also specifies the approach to determining an ACO's eligibility for the prior savings adjustment.

(5) Reducing the Impact of the Negative Regional Adjustment

CMS finalizes its proposal 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 will 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 finalizes 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 finalizes its proposal, with a technical correction to how the offset factor is calculated.

CMS will multiply the regional adjustments calculated by 1 minus an offset factor equal to the sum of the following: (A) Proportion of the ACO's BY3 assigned beneficiaries that are dually eligible for Medicare and Medicaid; and (B) The difference between the ACO's weighted average prospective HCC risk score for BY3 taken across the four Medicare enrollment types and 1. When calculating the weighted average prospective HCC risk score, the weight applied to the prospective HCC risk score for BY3 for each Medicare enrollment type is equal to the product of the BY3 per capita expenditures for that enrollment type and the BY3 person years for that enrollment type.

This offset factor will be applied to negative regional adjustments after the negative 1.5 percent cap is applied. The offset factor is subject to a minimum of zero and a maximum of one. The final adjustment is 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 74 in the final rule shows a hypothetical example of how an offset factor applies to

negative regional adjustments. In its simulations of this 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 revised 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 sought comment on these proposed changes to the calculation of the regional adjustment for agreement periods beginning on January 1, 2024, and in subsequent years.

Many commenters supported the proposal to: (1) 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, and (2) after the cap is applied to the regional adjustment, 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. Commenters believe that CMS' proposal will be beneficial as it will incentivize certain ACOs to join the program, such as those that are higher spending or care for underserved, complex, dually eligible, or high-cost beneficiaries. A few commenters indicated that they believe the proposed modifications to limit the impact of the negative regional adjustment will help their ACO(s) specifically, stating they serve high-cost or medically complex populations.

CMS agrees with commenters that the proposed policy would incentivize certain ACOs either to continue their participation in or to join the Shared Savings Program. After consideration of public comments, CMS finalizes its proposal to make changes to the calculation of the regional adjustment for agreement periods beginning on January 1, 2024. It made a modification to correct an error in the description of the methodology in the proposed rule and a non-substantive modification for consistency of terminology.¹⁵

(6) 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

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 for which CMS sought comment in the 2022 PFS proposed rule.

¹⁵ CMS modifies the text of §425.656(c)(4)(i) in this final rule to say "dually eligible for Medicare and Medicaid" instead of "dual eligible for Medicare and Medicaid" for consistency of terminology used in this final rule and elsewhere in the regulations.

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 2022 PFS proposed rule (86 FR 39292 and 39293). Shown as an equation this is:

$$(a) = [(b) \times (\text{ACO's regional market share})] + [(c) \times (1 - \text{ACO's regional market share})].$$

(a) = per capita risk adjusted FFS expenditures for all assignable beneficiaries in an ACO's regional service area.

(b) = weighted average of per capita risk adjusted FFS expenditures for the ACO's assigned beneficiaries

(c) = per capita risk adjusted FFS expenditures for assignable beneficiaries in the region who are not assigned to the ACO.

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:

$$(c) = \{(a) - [(b) \times (\text{ACO's regional market share})]\} / (1 - \text{ACO's regional market share}).$$

CMS 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 adopt 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 proposed 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 favored 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.

Discussion of Comments

Some commenters believed certain concerns CMS outlined in the proposed rule regarding the proposed Alternative 1 were unfounded. They believed there was no evidence to support CMS' concerns regarding potential beneficiary selection or market consolidation that would result from removing an ACO's assigned beneficiaries from the assignable population used in regional expenditure calculations. Other commenters urged CMS to adopt Alternative 2 to expand the ACO's regional service area, but did not specify an approach to doing so.

CMS continues to have concerns about adopting Alternative 1 as it believes that removing an ACO's assigned beneficiaries from the assignable beneficiary population used to compute regional expenditures would amplify the benefit to ACOs of selecting lower cost patients and 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. CMS does

not have the same concerns about unintended consequences from expanding the definition of an ACO's regional service area and believes that additional consideration of Alternative 2 is warranted. There are number of operational factors that it would need to address with greater specificity before deciding to adopt such an approach, such as what alternative geographic area it would use.

CMS may revisit the issue of expanding the definition of the ACO's regional service area in future rulemaking.

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 finalizes its 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 performance year. That is, for ACOs selecting prospective assignment, CMS 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 it will continue to use an assignable population of beneficiaries that is identified based on the calendar year assignment window. CMS is not changing the way it computes national factors that require identifying assignable populations.

To facilitate modeling of the changes, CMS made 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.¹⁶

Commenters were in general support of CMS' proposal to modify the calculation of risk-adjusted regional expenditures used in the regional adjustment and in the regional component of the blended factors used to trend and update the benchmark. Some commenters expressed concerns, including potentially lower benchmarks for ACOs under prospective assignment and a disproportionate impact on specific ACOs/ACO cohorts. CMS disagrees and believes that finalizing the proposed policy would bring greater consistency to the program, create a more

¹⁶ See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram?redirect=/sharedsavingsprogram/>

neutral choice between assignment methodologies, and increase incentives for ACOs under the prospective assignment methodology to grow more efficient over time.

CMS finalizes its proposed modifications to its methodology for calculating county FFS expenditures to provide for the use of separate assignment windows for ACOs depending on their selected assignment methodology

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 are as follows:

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 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 finalizes 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 will 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 will 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 will 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 is 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 are calculated as per capita historical benchmark expenditures for that enrollment type multiplied by the ACO's performance year assigned beneficiary person years for that enrollment type. The aggregate dollar-weighted average demographic risk ratio is 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 represents the aggregate cap.

Step 4: Determine prospective HCC risk score growth for each Medicare enrollment type.

Prospective HCC risk score growth is 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 ratio is then 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 76 in the final rule provides a numeric example of this methodology for a hypothetical ACO that is determined to be subject to the cap. Table 77 shows an example where 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 benchmarks under the finalized policy than the current policy.

CMS sought comment on the proposed changes to the risk adjustment methodology for agreement periods beginning on or after January 1, 2024.

Many commenters supported CMS' 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, aged/non-dual eligible). Several commenters stated that they believe this proposed change to risk adjustment methodology would create a benchmark that is fairer and more equitable, more representative of an ACO's assigned population, and effectively guard against coding initiatives while balancing incentives for ACOs to care for high-risk beneficiaries. Other commenters cautioned that it may introduce complexity and less financial certainty. MedPAC supported accounting for all changes in demographic risk scores prior to applying the cap but disagreed with CMS' proposal to maintain the 3 percent cap after accounting for demographic risk scores, believing it should be reduced. Several commenters requested that the cap be placed on negative changes in risk scores or a "symmetrical cap". Others recommended raising the cap to 5 percent or even removing the cap on increases in diagnosis risk score, as well as demographic risk scores.

CMS agrees with commenters that the proposed policy addresses several of the concerns previously raised by interested parties by 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 and continuing to safeguard the Trust Funds by

limiting returns from coding initiatives. The proposed policy also accounts for potentially significant changes in prospective HCC risk scores for certain enrollment types due to the smaller number of assigned beneficiaries in those enrollment types. Based on its modeling, ACOs would be much less likely to have prospective HCC risk ratios for ESRD, disabled, and aged/dual eligible Medicare enrollment types capped under the proposed policies, which should improve the incentives for ACOs to treat these medically complex, high-cost populations. At the same time, CMS believes that the proposed policy would continue to protect the Trust Funds by continuing to limit incentives for coding intensity, as it would retain the 3 percent cap on growth in prospective HCC risk scores after accounting for all changes in demographic risk scores for the ACO's assigned beneficiary population.

CMS disagrees with MedPAC and believes there are valid reasons to allow some prospective HCC risk score growth beyond demographic risk score growth. For example, there may be natural variation over time in the health of an ACO's assigned population, an ACO may establish new services that provide care for medically complex populations in their regional service area, or an ACO may attract a sicker population over time in response to Shared Savings Program policies designed to encourage ACOs to care for these populations. At this time, CMS declines to lift the cap on positive adjustments resulting from changes in prospective HCC risk scores above 3 percent. CMS believes that further increasing the cap would allow for excessive returns for coding initiatives. It also declines to consider an approach that would limit the impact of prospective HCC risk score decreases at this time. CMS believes such an approach would encourage favorable risk selection. If ACOs seek to attract low-cost beneficiaries or avoid high-cost beneficiaries, they could lower their performance year expenditures without a corresponding adjustment to their benchmark due to the cap on negative prospective HCC risk adjustments.

CMS finalizes its proposed modifications to the risk adjustment methodology 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, aged/non-dual eligible). It made one modification to correct an error in the description of the methodology for calculating of the weighted average demographic and prospective HCC risk scores in the proposed rule.

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 finalizes its proposal 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.¹⁷ 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 alternative quality performance standard, the sharing rate will be further adjusted according to that policy, which will reinstate a sliding scale approach for determining shared savings using the ACO's quality performance score, including the health equity adjustment bonus points described earlier.

Commenters generally supported this proposal citing the potential for ACOs to invest the savings earned under this policy in care redesign and quality improvement activities. Some recommended extending the opportunity to share in savings at a reduced rate to all ACOs. Some commenters cited the significant number of ACOs that generate some savings, but not enough to earn shared savings payments, and stated their belief that extending this proposal to all ACOs would help incentivize ACOs to remain in the program. A couple of commenters argued that high revenue, hospital-led ACOs (like low revenue, physician-led ACOs) often include independent physicians and that they would be more likely to participate in the Shared Savings Program and engage in meaningful transformation if the likelihood of savings increased.

CMS continues to believe it is appropriate to limit this policy to low revenue ACOs participating in the BASIC track, as proposed, in order to attract ACOs that serve higher spending populations into the BASIC track, particularly low revenue, physician-led ACOs that have historically performed well in the program. By supporting ACOs with the greatest need for capital, in particular smaller, rural ACOs, which tend to be less capitalized, CMS expects this policy to increase participation among these ACOs and provide additional support for investments in care redesign and quality improvement activities. It continues to believe that high revenue ACOs have sufficient resources to support continued participation given they are generally composed of hospitals and health systems that have greater access to capital for investing in care redesign, better care coordination, and quality improvement.

¹⁷ 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.

CMS finalizes the proposal to increase opportunities for eligible low revenue ACOs to share in savings as proposed. It will also use an ACO's health equity adjusted quality performance score, which, as discussed in section III.G.4.b.(7) of this final rule, will incorporate LIS status in addition to dually eligible beneficiary status and Area Deprivation Index (ADI) in the calculation of the underserved multiplier, to determine the ACO's eligibility to share in savings and the amount of shared savings for ACOs that meet the alternative quality performance standard.

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):

- 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;¹⁸

¹⁸ 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.

- 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.

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 its policy to utilize a three-way blend of the ACPT/national-regional growth rates to update benchmarks (described earlier in this summary) will 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.

Several commenters expressed concern about including 2020 and 2021 as benchmark years due to the impact of COVID-19 on expenditures and utilization rates. These commenters noted that other Medicare programs have not used years affected by COVID-19 when determining financial or quality benchmarks and requested that CMS extend this policy to the Shared Savings Program. In response, CMS states that its analysis of the 3-year weighted average expenditures used to calculate PY2022 final historical benchmarks, show that historical benchmarks averaged across a base period including both 2020 and 2021, appear to represent a reasonable basis from which to establish ACO spending targets. It also notes that it did not propose any changes in the 2023 PFS proposed rule to address the impact of the PHE for COVID-19 on ACOs’ expenditures, but will continue to monitor its impact.

h. 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 final rule (87 FR 49047 through 49051), CMS finalized its proposal to establish a new supplemental payment for IHS/Tribal hospitals and hospitals located in Puerto Rico, beginning in FY 2023.

In this final rule, CMS finalizes its proposal to exclude these new supplemental payments 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.¹⁹ However, when calculating ACO participant revenue,²⁰ CMS finalizes its proposal to include these new supplemental payments, also consistent with the treatment of IME, DSH and uncompensated care payments.

CMS received one comment in support of this proposed policy. CMS finalizes its proposal.

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 modifications to the benchmarking methodology. The technical details of its technical and conforming changes can be found in this section.

CMS did not receive any comments specifically addressing the organization and structure of the regulations text within 42 CFR part 425 subpart G, or the technical and conforming changes. CMS finalizes these changes as proposed with the exception of minor technical corrections to the structure and formatting of §425.601(d).

6. **Reducing Administrative Burden and Other Policy Refinements**

Beginning with performance year 2023 and for subsequent years, CMS finalizes as proposed burden reduction proposals related to ACO marketing materials and beneficiary notification requirements. Also finalized as proposed starting in 2023 are refinements to the SNF 3-day rule waiver process and data sharing regulations. All proposals will begin with PY 2023.

a. **Requirements for ACO Marketing Materials (§425.310)**

CMS finalizes the elimination of 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 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.

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 (4) not be materially inaccurate or misleading. ACOs will remain subject to sanctions (including termination) if they fail to comply with the requirements of the reorganized section.

¹⁹ If included, they would have affected the determination of benchmark and performance year expenditures.

²⁰ 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.

Most commenters were supportive. Some requested flexibility to tailor CMS template language to the features of their ACOs. A few opposed the marketing materials process changes, stating that the materials represent a significant ACO-beneficiary communication channel and should have close CMS oversight.

CMS disagrees and notes that only 1 of 241 marketing items undergoing advance review in 2021 was denied. CMS denies the request to allow template language flexibility in support of encouraging standardization and transparency across ACOs.

b. Beneficiary Notification Requirements (§425.312)

Notification frequency and form

CMS finalizes as proposed reduction of the frequency with which standard (templated) beneficiary information notices are provided from annually to a minimum of once per ACO agreement period. Concomitantly CMS finalizes as proposed that after providing the notice the ACO must follow up with the beneficiary. Follow up must occur at the beneficiary's next primary care service visit or no later than 180 days after the notice has been provided. The follow-up communication may take verbal or written form but must be tracked and documented by the ACO; documentation must be available to CMS upon request. The notification and follow up requirements are applicable to all ACOs regardless of choice of assignment methodology (prospective or preliminary prospective with retrospective reconciliation).

Most commenters supported decreasing the frequency for providing required written beneficiary notices. However, most commenters opposed the new requirement for a documented follow up communication about the notice within 180 days after the notice has been given to the beneficiary. Reasons offered included creating new burden for ACOs and causing beneficiary confusion by multiple interactions about the same materials.

CMS states that overall notification burden is being reduced. Further, CMS views the follow up communication, during which the beneficiary is given a meaningful opportunity to engage with an ACO representative and to ask questions, as an important contribution to the ACO-patient relationship.

Signage posting clarifications

CMS also finalizes regulation text changes to clarify requirements for posting of beneficiary notification signage in facilities where ACO participants furnish services, including all sites where patients are seen by ACO providers, whether primary care or specialist practitioners.²¹ CMS further clarifies that only sites furnishing primary care services must provide the

²¹ The signage (template poster) 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.

standardized written notice upon beneficiary request. Clarifications are codified in a redesignated section at §425.312(a)(2)(ii).

Comments were few but generally supportive of the clarifications. One commenter identified language in the template signage that will need updated to conform with the clarifications. CMS indicates that the template signage will be updated appropriately and that other template language revisions for the signage and standard written notice are underway based on input from recent beneficiary focus group sessions.

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

CMS finalizes as proposed streamlining the application process by which an ACO requests access to the Shared Savings Program's waiver of the SNF 3-day rule. Specifically, an ACO will no longer be required to submit narratives with its application detailing its communication plan, care management plan, and beneficiary evaluation and admission plan. The narratives must be prepared and made available to CMS upon request.

The SNF 3-day rule waiver, allowing an assigned beneficiary to be discharged to and receive inpatient SNF care without a prior 3-day inpatient hospital stay, may be requested by ACOs that bear two-sided risk. 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.²²

Most comments received were supportive. A concern was voiced that the changes will not address the existing lack of understanding by beneficiaries about the waiver. A suggestion was made that more data about utilization of the SNF waiver by ACOs be made publicly available so that effects on beneficiary access can be analyzed. Some recommended extending availability of the waiver to ACOs on one-sided risk tracks.

CMS responds that the changes do not alter the Medicare SNF benefit and do not require targeted beneficiary outreach efforts by the agency. Beneficiaries should be informed about the waiver by their ACOs during hospital discharge planning. CMS will consider publicly releasing additional waiver utilization data. CMS categorizes the request to expand waiver availability as being out of scope of this rule.

d. Data Sharing Regulations (§425.702)

CMS finalizes as proposed to specify that ACOs operating as organized health care arrangements (OHCAs) may request aggregate reports and beneficiary-identifiable claims data reports from CMS.²³

Most commenters supported the proposal. Some stated that the proposal does not aid ACOs in reporting all-payer data to meet the quality standard requirements of the Shared Savings

²² SNF Affiliates have written agreements with their partnering ACOs, and each ACO must maintain a list of its SNF Affiliates.

²³ OHCA are defined at 45 CR 160.103 (the HIPAA regulations).

Program.²⁴ The difficulties of aggregating data within ACOs whose member providers do not share a common EHR would not be changed for ACOs operating as OHCAs versus the predominant existing arrangement of business associate agreements between the ACO and its providers and suppliers. These commenters further asserted that using data from patients outside those assigned to an ACO to measure the ACO's quality performance is inappropriate regardless of an ACO's operational data-sharing structure.

CMS responds that allowing ACOs the option to operate as OHCAs is designed solely to recognize another acceptable potential structure through which an ACO can engage in data-sharing with CMS. CMS acknowledges the challenge of aggregating data within an ACO across EHRs but continues to view ACO quality measures that require all-payer data as the best mechanism for appropriately assessing the quality of care delivered by each ACO.

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 sought 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 which may limit savings for the Medicare program).

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 BY3 and the performance year. MedPAC and researchers are also examining the Shared Savings Program benchmarking

²⁴ The Program is in the midst of transitioning from Medicare-only patient data reporting to all-payer reporting and will be fully implemented for performance year 2025 and thereafter.

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.

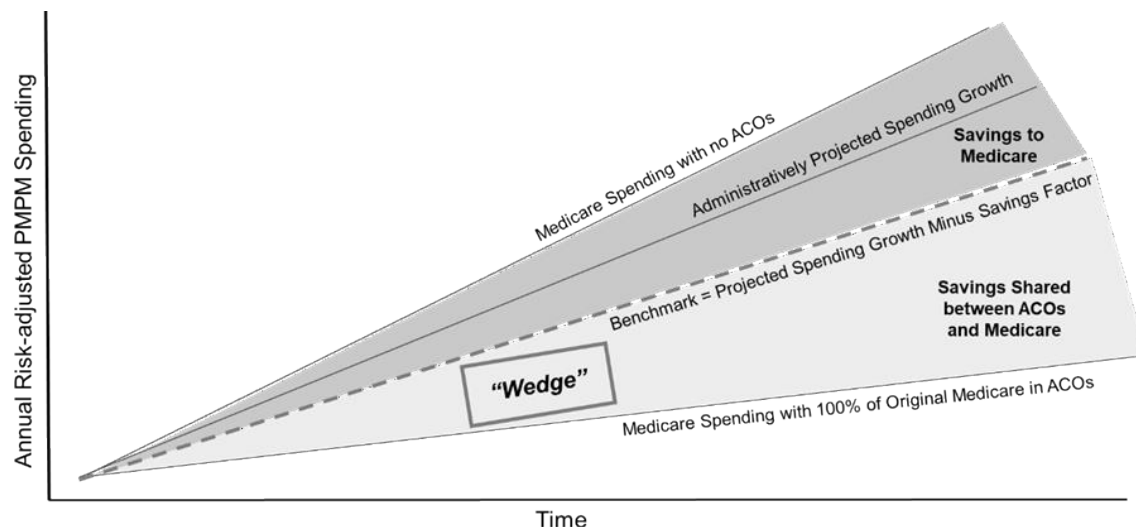
The RFI sought to gather information regarding a potential alternative approach to calculating ACO historical benchmarks that would use administratively set benchmarks that are decoupled from ongoing observed FFS spending. CMS sought comments on the concept of utilizing a prospective, administratively set benchmark in the Medicare Shared Savings Program, which are summarized at the end of this section.

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

In this section, CMS described and sought 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 final 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 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.

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 sought comment on these considerations for calculating an ACPT to be used as an administratively set benchmark update factor. It sought 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 sought 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 sought 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, CMS would calculate a measure of the ACO's regional efficiency. It 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 the composition of ACO participant TINs during an 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 sought 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 sought comment on considerations for limiting disincentives for efficient ACOs to add less efficient providers and suppliers.

(5) Detailed Administratively-Established Benchmark Update Calculation

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 sought 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. Discussion of Comments on Administratively Set Benchmarks

The vast majority of commenters expressed general support for the concept of utilizing a prospective, administratively set benchmark in the Medicare Shared Savings Program. These commenters expressed the need to address the ratchet effect, through which ACOs' benchmarks are impacted by the individual and collective savings generated by ACOs. Many commenters shared factors CMS should consider for implementation of an administrative benchmarking approach. These included the following:

- Regional adjustments to the administratively-set benchmark trends.
- Glidepath to administrative benchmarks to mitigate short-term windfall gains/losses due to regional spending variations or forecasting errors.
- Retrospective adjustments to an administrative benchmark based on observed changes in regional prices and demographics only.
- Interaction of the administrative benchmarking approach with the Medicare Advantage program.
- Removal of shared savings payments from the calculation of any administrative benchmark trend based on the USPCC.
- Separate benchmarking approach for very high-cost, high-needs populations as convergence to a common regional risk-adjusted benchmark may not be possible in this patient population.
- Application of a variable discount rate to the benchmark trend according to an ACO's risk-adjusted spending relative to its region allowing for gradual convergence to a common regional benchmark.

Commenters expressed differing views on the timing of a transition to an administrative benchmarking methodology. Several commenters expressed urgency in implementing this benchmarking methodology, citing the growing impact of the ratchet effect and a desire to grow

the Medicare Shared Savings Program. Other commenters believed there was not an urgent need to move to administrative benchmarks and some questioned the timing of introducing administrative benchmarks given volatility introduced by the COVID-19 pandemic.

In response, CMS states that it will consider these comments in the development of policies for future rulemaking. It notes the similarity of comments it received in response to its proposal to incorporate the ACPT into the Shared Savings Program. In particular, CMS stated that it would give more thought to the use of variable discount factors as a means to drive gradual convergence to a common regional benchmark

f. 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 sought 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.

The vast majority of commenters expressed support for exploring methodologies to address health equity via benchmarking changes. Specifically, many of these commenters noted that benchmark adjustments could be an effective tool to redirect resources to ACOs serving underserved communities. Several of the commenters expressed support for the health equity benchmark adjustment approach utilized in ACO REACH. Others expressed concern regarding the “budget neutral” approach adopted in ACO REACH, whereby higher benchmarks for underserved populations were offset by lower benchmarks for other populations. Other suggestions included equity-motivated benchmark adjustments that would provide higher benchmarks to ACOs that include safety net providers, such as CAHs, FQHCs, RHCs, and REHs, and adjustments for ACOs serving rural areas. Another commenter suggested that any health equity motivated changes to the Shared Savings Program be considered holistically across multiple program features such as quality metrics and risk adjustment rather than focused on benchmarking alone.

One commenter expressed concerns with the potential use of the ADI to identify underserved populations, and specifically noted that ADI does not incorporate race or ethnicity variables. They recommended that CMS consider using the Social Vulnerability Index because that index includes race as a variable which may account for the impact of structural racism on health care utilization and outcomes.

CMS replies that it appreciates the thoughtful comments and will consider them in the development of policies for future rulemaking.

8. Impact on Medicare Shared Savings Program

CMS notes that its 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 policies 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 final 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 152, reproduced below). The impact estimate ranges from a reduction of \$8.2 billion to a reduction of \$21.4 billion at the 10th and 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 152: Final 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						