Physician Fee Schedule Final Rule for 2024
Summary Part II

Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program
[CMS-1784-F]

On November 2, 2023, the Centers for Medicare & Medicaid Services (CMS) placed on public display a final rule relating to the Medicare physician fee schedule (PFS) for CY 2024[1] and other revisions to Medicare Part B policies. The final rule is scheduled to be published in the November 16, 2023 issue of the *Federal Register*. Policies in the final rule generally would take effect on January 1, 2024.

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

The policies related to the Medicare Shared Savings Program are designed to strengthen financial incentives for long-term participation and further Medicare's overall value-based care strategy of growth, alignment, and equity. The policies in this final rule are incremental refinements to the broader changes CMS finalized in the 2023 PFS final rule (87 FR 69777 through 69968).

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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, 2023, almost 11 million people with Medicare receive care from one of the 573,126 health care providers in the 456 ACOs participating in the Shared Savings Program.

CMS says policies in this final rule are intended to further advance Medicare's overall value-based care strategy of growth, alignment, and equity, and to respond to concerns raised by ACOs and other interested parties. CMS revises the following policies:

- Revises the quality reporting and the quality performance requirements, including the following:
    - Allows Shared Savings Program ACOs the option to report quality measures under the Alternative Payment Model (APM) Performance Pathway (APP) on only their Medicare beneficiaries through Medicare clinical quality measures (CQMs).
    - Updates the APP measure set for Shared Savings Program ACOs.
    - Revises the calculation of the health equity adjustment underserved multiplier.
    - Uses historical data to establish the 40th percentile Merit-based Incentive Payment System (MIPS) Quality performance category score used for the quality performance standard.
    - Applies a Shared Savings Program scoring policy for excluded APP measures and those that lack a benchmark.
    - Requires Spanish language administration of the CAHPS for MIPS survey.
    - Aligns certified electronic health record (EHR) technology (CEHRT) requirements for Shared Savings Program ACOs with MIPS.
    - Revises the requirement to meet the case minimum requirement for quality performance standard determinations.
- Revises the policies for determining beneficiary assignment as follows:
    - Modifies the step-wise beneficiary assignment methodology and approach to identifying the assignable beneficiary population.
    - Updates the definition of primary care services used in beneficiary assignment.
- Revises the policies on the Shared Savings Program's benchmarking methodology as follows:
    - Modifies the calculation of the regional update factor used to update the historical benchmark between benchmark year (BY) 3 and the performance year (PY) by

[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.

capping an ACO's regional service area risk score growth through use of an adjustment factor to provide more equitable treatment for ACOs and for symmetry with the cap on ACO risk score growth.
    - Further mitigates the impact of the negative regional adjustment on the benchmark to encourage participation by ACOs caring for medically complex, high-cost beneficiaries.
    - Specifies the circumstances in which CMS recalculates the prior savings adjustment for changes in values used in benchmark calculations due to compliance action taken to address avoidance of at-risk beneficiaries, or as a result of the issuance of a revised initial determination of financial performance for a previous performance year.
    - Specifies use of the CMS-Hierarchical Condition Category (HCC) risk adjustment methodology applicable to the calendar year corresponding to the performance year in calculating prospective HCC risk scores for Medicare FFS beneficiaries for the performance year, and for each benchmark year of the ACO's agreement period.
- Refines advance investment payments (AIP) policies, including the following:
    - Modifies AIP eligibility requirements to allow an ACO to elect to advance to a two-sided model level of the BASIC track's glide path beginning with the third performance year of the 5-year agreement period in which the ACO receives advance investment payments.
    - Modifies AIP recoupment and recovery polices to forgo immediate collection of advance investment payments from an ACO that terminates its participation agreement early in order to early renew under a new participation agreement to continue their participation in the Shared Savings Program.
    - Modifies termination policies to specify that CMS immediately terminates advance investment payments to an ACO for future quarters if the ACO voluntarily terminates from the Shared Savings Program.
    - Modifies ACO reporting requirements to require ACOs to submit to CMS the same spend plans that the ACO must report publicly. s
    - Modifies AIP requirements to permit ACOs to seek reconsideration review of all quarterly payment calculations.
- Updates Shared Savings Program eligibility requirements, including the following:
    - Removes the option for ACOs to request an exception (for agreement periods on or after January 1, 2024) to the shared governance requirement that 75 percent control of an ACO's governing body must be held by ACO participants.
    - Codifies the existing Shared Savings Program operational approach to specify that CMS determines that an ACO participant TIN participated in a performance-based risk Medicare ACO initiative if it was included on a participant list used in financial reconciliation for a performance year under performance-based risk during the five most recent performance years.
- Makes technical changes to references in Shared Savings Program regulations.

CMS also summarizes comments it received on potential future developments to Shared Savings Program policies, including with respect to incorporating a new track that would offer a higher level of risk and potential reward than currently available under the ENHANCED track, refining the three-way blended benchmark update factor and the prior savings adjustment, and promoting ACO and community-based organization (CBO) collaboration.

CMS projects a $330 million decrease in total program spending over the 10-year period 2024 through 2033. These changes are anticipated to support growth in this program with a particular focus on including underserved beneficiaries.

2. Quality Performance Standard and Reporting Requirements

a. Background

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 the 10 CMS Web Interface measures or the 3 electronic clinical quality measures (eCQMs) or clinical quality measures (CQMs) of the APM Performance Pathway (APP) of the Merit-based Incentive Payment System (MIPS), in addition to the CAHPS for MIPS survey.[4] Beginning with PY 2025, ACOs must report the 3 eCQMs/MIPS CQMs and the CAHPS for MIPS survey through the APP.

b. Option for Shared Savings Program ACOs to Report Medicare CQMs

Overview. To assist ACOs gain infrastructure, skills, and expertise in reporting all payer/all patient MIPS CQMs and eCQMs, CMS is finalizing with modifications (as discussed below) its proposal for PY 2024 and subsequent PYs determined by CMS, to establish a temporary, new transition collection type option (the Medicare CQMs) as an alternative to eCQMs or CQMs for ACOs participating in the Shared Savings Program to report quality data on eligible beneficiaries. The Medicare CQMs will be similar to the MIPS CQMs but will be reported by an ACO under the APP on only the ACO's Medicare FFS beneficiaries, instead of its all payer/all patient population. It ties the defined population of beneficiaries within the all payer/all patient MIPS CQM specifications to claims encounters with ACO professionals with specialties used in assignment. Therefore, CMS believes Medicare CQMs will be most useful to ACOs with a higher proportion of specialty practices.

To report Medicare CQMs, an ACO will aggregate patient data for eligible beneficiaries across all ACO participants and match the aggregated patient data with each Medicare CQM specification to identify the eligible population for each measure. To assist ACOs in this process, for performance year 2024 and subsequent performance years, CMS will provide the ACO with

[4] 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.

a list of, and specified information regarding, beneficiaries who are eligible for Medicare CQMs within the ACO. The finalized timing for provision of this list is modified, pursuant to comment. Instead of providing a list annually, as proposed, CMS will provide a quarterly list of beneficiaries eligible for Medicare CQMs to provide ACOs with more frequent cumulative lists.

Beneficiaries eligible for Medicare CQMs. CMS finalizes its proposal, with the noted modification below, to define beneficiaries eligible for Medicare CQMs as beneficiaries who are either (i) a Medicare FFS beneficiary who meets the criteria for a beneficiary to be assigned to an ACO and had at least one claim with a date of service during the measurement period from an ACO professional who is a primary care physician, has a specialty designation described in §425.402(c), or is a PA, NP, or clinical nurse specialist; or (ii) a Medicare FFS beneficiary assigned to an ACO because the beneficiary designated a professional participating in the ACO as coordinating their care. CMS notes a modification to what it had proposed that corrects where the proposed definition had incorrectly referenced "certified nurse specialist" instead of "clinical nurse specialist".

Data completeness threshold. CMS finalizes its proposal for a data completeness criteria threshold for Medicare CQMs of at least 75 percent for 2024-2026 performance years/2026-2028 MIPS payment years. However, CMS is not finalizing its proposal to increase the data completeness threshold to at least 80 percent for the 2027 performance years/2029 MIPS payment year.

Measures. CMS finalizes under section IV.A.4.e. of the rule to add as Medicare CQMs the 3 all payer/all patient eCQMs/MIPS CQMs finalized under the APP—Diabetes: Hemoglobin A1c Poor Control, Preventive Care and Screening: Screening for Depression and Follow-Up Plan, and Controlling High Blood Pressure.

In PY 2024, ACOs could therefore report the 10 CMS Web Interface measures or the 3 eCQMs, MIPS CQMs, or Medicare CQMs. In addition, ACOs are required to administer the CAHPS for MIPS survey and CMS will calculate the 2 claims-based measures. Beginning in PY 2025 the same would apply, except the CMS Web Interface measures will no longer be an option.

Benchmarks. CMS is finalizing its proposal that benchmarks for scoring ACOs on the Medicare CQMs under MIPS be aligned with MIPS benchmarking policies.[5] For PYs 2024 and 2025, it will score Medicare CQMs using performance period benchmarks (since historical Medicare CQM data will not yet be available). Beginning with PY 2026, CMS will transition to using historical benchmarks when baseline period data are available.

Health Equity Adjustment. In the CY 2023 PFS final rule (87 FR 69838 through 69858), beginning for PY 2023, CMS finalized a health equity adjustment to increase the MIPS quality performance score for ACOs that (i) report eCQMs/MIPS CQMs, (ii) are high performing on quality, and (iii) serve a higher proportion of underserved beneficiaries. CMS finalizes its proposal that, beginning with PY 2024, ACOs that report Medicare CQMs also be eligible for the health equity adjustment.

[5] MIPS benchmarking policies are at §414.1380(b)(1)(ii).

Selected Comments/Responses. Many commenters supported the proposal to establish Medicare CQMs, agreeing that reporting on Medicare patients will help ACOs transition to all payer reporting and that the new collection type may encourage more ACOs to transition into accountable care in the Shared Savings Program. Several commenters raised concern about the implementation of Medicare CQMs in performance year 2024, but CMS believes its appropriate since they are an optional collection type. In response to other comments, the agency clarified it will provide technical guidance and specifications to ACOs to support them in the identification of beneficiaries eligible for Medicare CQMs.

Several commenters raised concerns about data aggregation and deduplication, including that the Medicare CQMs would not resolve underlying challenges with electronic quality measurement, which requires manual data aggregation and patient matching across TINs and EHR types. CMS recognizes these challenges but believes that movement toward digital quality data will help further ACOs' care coordination and quality improvement capabilities. CMS will also provide ACOs with a list of beneficiaries eligible for Medicare CQMs to support ACOs in the aggregation and deduplication of data. CMS also clarifies that Medicare CQMs may be submitted by the ACO or a third party intermediary as they would be subject to the data submission requirements at §414.1325.

Many commenters were concerned that the agency's proposal to provide a list of beneficiaries who are eligible for Medicare CQMs would add significant burden for ACOs to ensure the list is complete. In response, CMS is modifying its proposal, which had been to provide the list once annually (at the beginning of the quality data submission period), to instead provide each ACO a list each quarter throughout the performance year as part of the ACO's Quarterly Informational Reports Packages. The list will be cumulative and updated quarterly to reflect the most recent quarter's data. ACOs should use all available data, including the lists provided by CMS, to ensure the ACO's data is accurate and complete.

Concern was raised about this reporting option being temporary, including that EHR vendors may not support Medicare CQMs since it is a temporary reporting option. Another commenter suggested understanding the timeline for sunsetting the temporary option would be useful. The agency responds that it expects that the sunset may be timed with the uptake of FHIR API technology, but that would be assessed going forward.

Several commenters raised concern about the proposed data completeness criteria thresholds. CMS responds that the threshold of at least 75 percent for the Medicare CQMs aligns with that for eCQM and MIPS CQM collection types, which it believes is appropriate.

Summary of Final Policies. Table 28 of the final rule (represented with organizational changes below) summarizes the finalized changes to the APP quality reporting requirements.

Final APP Reporting Requirements and Quality Reporting Standard for PY 2024 and Subsequent PYs (Based on Table 28 in the rule with formatting modifications)		
	PY 2024	**PY 2025 and Subsequent Years**
Quality Reporting Requirements	Report 10 Web Interface measures or the 3 APP eCQMs/MIPS CQMs/Medicare CQMs; and	Report the 3 APP eCQMs/MIPS CQMs/Medicare CQMs; and administer CAHPS for MIPS survey.

Final APP Reporting Requirements and Quality Reporting Standard for PY 2024 and Subsequent PYs (Based on Table 28 in the rule with formatting modifications)		
	PY 2024	**PY 2025 and Subsequent Years**
	administer CAHPS for MIPS survey. CMS calculates 2 claims-based measures.	CMS calculates 2 claims-based measures.
Quality Performance Standard Including the Proposed Health Equity Adjustment	A health-equity adjusted score that is ≥ 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 that is ≥ 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 ≥ the 40th percentile across all MIPS Quality performance category scores (excludes those eligible for facility-based scoring*)
Alternative Quality Performance Standard	Fails to meet 2024 criteria above but a quality performance score that is ≥ 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 a quality performance score that is ≥ than 10th percentile of performance benchmark on ≥ 1 (of 4) APP outcome measures would allow shared savings (if otherwise eligible) at a lower rate that is scaled by the ACO's quality performance score
Quality Performance Standard 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/Medicare 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.	If an ACO (1) does not report any of the 3 APP eCQMs/MIPS CQMs/Medicare CQMs and (2) does not administer a CAHPS for MIPS survey, the ACO will not meet the quality performance standard or the alternative quality performance standard.
* Facility-based scoring allows certain clinicians (e.g., pathologists) to be scored using their facilities' Hospital Value Based Purchasing Program results.		

c. APP Measure Set

Table 29 of the rule shows the measures included in the APP measure set for PY 2024 and subsequent PYs. The below table represents information included in that table. The newly finalized Medicare CQMs are included as an additional collection type.

Measures Included in APP Measure Set Beginning with PY 2024				
Measure ID #	**Measure Title**	**Measure Type**	**Collection Type**	**SSP Quality Performance Standard##**
Q321	CAHPS for MIPS Survey	Patient-Reported Outcome	CAHPS for MIPS Survey	MIPS Comparable Measure: Yes Outcome Measure: No
Q479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Outcome	Administrative Claims	MIPS Comparable Measure: Yes Outcome Measure: Yes
Q484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Outcome	Administrative Claims	MIPS Comparable Measure: Yes Outcome Measure: Yes
Q001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	Intermediate Outcome	eCQM/MIPS CQM/Medicare CQM/CMS Web Interface*	MIPS Comparable Measure: Yes Outcome Measure: Yes
Q134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	Process	eCQM/MIPS CQM/Medicare CQM/CMS Web Interface*	MIPS Comparable Measure: Yes Outcome Measure: No
Q236	Controlling High Blood Pressure	Intermediate Outcome	eCQM/MIPS CQM/Medicare CQM/CMS Web Interface*	MIPS Comparable Measure: Yes Outcome Measure: Yes
Q318	Falls: Screening for Future Fall Risk	Process	CMS Web Interface*	NA
Q110	Preventive Care and Screening: Influenza Immunization	Process	CMS Web Interface*	NA
Q 226	Preventive Care and Screening: Tobacco Use Screening and Cessation Intervention	Process	CMS Web Interface*	NA
Q113	Colorectal Cancer Screening	Process	CMS Web Interface*	NA
Q112	Breast Cancer Screening	Process	CMS Web Interface*	NA
Q438	Statin Therapy for the Prevention and** Treatment of Cardiovascular Disease	Process	CMS Web Interface*	NA
Q370	Depression Remission at 12 Months**	Outcome#	CMS Web Interface*	

* ACOs will have the option to report via the CMS Web Interface for performance year 2024 only.
** These measures do not have benchmarks and therefore are not scored for PY 2024, but are required to be reported to complete the Web Interface data set.
# This measure is not included as one of the four outcome measures for purposes of the Quality Reporting Standard as this measure is not scored.
Relevant for ACOs reporting on eCQM/MIPS CQMs to qualify for incentives under §425.512(a)(4)(i)(B) for PY 2024.

d. Modifications to the Health Equity Adjustment Underserved Multiplier

Background. In the 2023 PFS final rule (87 FR 69826 through 69857) CMS finalized the application of a health equity adjustment. Up to 10 bonus points are added to an ACO's MIPS quality performance category score for qualifying ACOs to reward ACOs that both have high performance scores on quality measures and serve a high proportion of underserved beneficiaries. A health equity adjustment is available only to ACOs that report using the 3 eCQMs/MIPS CQMs (or, as newly finalized, Medicare CQMs beginning with PY 2024) of the APP measure set and meet data completeness requirements for each of these measures. In addition, the ACO is required to administer the CAHPS for MIPS survey.

The health equity adjustment bonus points are calculated by multiplying:

- The ACO's performance scaler (which is determined based on whether the ACO's measure performance was in the top, middle, or bottom third of ACO performance for the PY); by
- The ACO's underserved multiplier (which is a proportion, ranging from 0 to 1, of the ACO's assigned beneficiary population for the PY that is considered underserved).
    - The proportion of the ACO's assigned beneficiary population that is considered underserved is based on the highest of (i) the proportion of the ACO's assigned beneficiaries residing in a census block group with an Area Deprivation Index (ADI) national percentile rank of at least 85, or (ii) the proportion of such assigned beneficiaries who are enrolled in the Medicare part D LIS or are dually eligible for Medicare and Medicaid).[6]

Revisions. CMS finalizes its proposal to revise the underserved multiplier calculation by removing beneficiaries without a numeric national percentile rank available for ADI from the health equity adjustment calculation beginning for PY 2023, so that they appear neither in the numerator nor denominator of the proportion. CMS had not previously proposed a rule for how to count this population. CMS believes this approach is more equitable than imputing a score for beneficiaries without such a rank available for ADI. CMS notes that, since the multiplier calculation counts only those with an ADI of at least 85 in the numerator, an imputation of a score under 85 (such as how a score of 50 percent is imputed for the advance investments payments (AIP) risk factors-based score) would (unlike in the calculation for the AIPs) penalize ACOs by counting those beneficiaries in the denominator of the ratio but not in the numerator.

CMS believes failure to apply the proposed removal of beneficiaries without an ADI national percentile rank from the health equity adjustment calculation would leave a gap in how to treat such beneficiaries in the calculation and may unfairly penalize ACOs, which would be contrary to public interest. Therefore, CMS is finalizing that the revision, consistent with public interest, will apply retroactively to PY 2023.[7]

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[6] For more details on the health equity adjustment calculation see the CY 2023 PFS final (87 FR 69843 through 69849).

[7] Section 1871(e)(1)(A)(ii) of the Act authorizes the Secretary to retroactively apply a substantive change through regulation if the Secretary determines that failure to do so would be contrary to public interest.

CMS is also finalizing its proposal, beginning for PY 2024, to modify the calculation of the proportion of assigned beneficiaries dually eligible for Medicare and Medicaid or enrolled in Medicare part D LIS to include those with partial year dual eligibility or LIS enrollment by using the number of beneficiaries rather than person years. The underserved multiplier will now use the number of assigned beneficiaries with any months enrolled in LIS or dually eligible divided by the total number of assigned beneficiaries, whereas the "person year" included only the fraction of the year in which the individual was eligible for dual or LIS status.

Selected Comments/Responses. Most commenters supported the proposed modification to the health equity adjustment underserved multiplier. Several commenters expressed concern with using the national ADI rank score including because it overly relies on income and home values, can mask urban poverty, and may not be a good proxy for patient-level social risk factors. CMS clarifies that it did not propose any changes to the previously finalized use of the national ADI rank score, but proposed to exclude beneficiaries without a national percentile ADI rank from the health equity adjustment underserved multiplier. The comments are therefore out of scope, but the agency indicates it will continue to assess the impact of using the national ADI, including the use of state ADI in the health equity adjustments used in CMMI innovation models.

e. Use of Historical Data to Establish the 40th Percentile MIPS Quality Performance Category Score

Background. One way an ACO can meet the Shared Savings Program quality performance standards and share in savings at the maximum rate under its track is by the ACO achieving a health equity adjusted quality performance score that is equal to or greater than the 40th percentile across all MIPS quality performance category scores.[8] The 40th percentile score is calculated by taking the 40th percentile of all submission-level MIPS quality performance category scores (the unweighted distribution), excluding providers eligible for facility-based scoring. CMS describes comments in response to past proposed rules that raised concern that ACOs do not have advance information to determine what quality performance score they would need in order to satisfy this quality performance standard since data are not publicly available before the start of a PY. CMS describes several MIPS scoring policies and how their evolution could affect the year-to-year comparability of MIPS quality performance category scores. CMS believes that the use of multiple years of historical data could be used to smooth out the impact of such MIPS scoring policy changes in any one year.

Revisions. Beginning for PY 2024 CMS is finalizing its proposal to use a rolling 3-PY historical average with a lag of one PY to calculate the 40th percentile MIPS quality performance category score. For example, the 40th percentile MIPS quality performance category score used for PY 2024 will be based on averaging the 40th percentile scores from PYs 2020-2022 (with 2023 being the gap/lag year). CMS will provide this historical measure for a PY prior to the start of the PY (i.e., the 40th percentile historical score used for PY 2024 will be released December 2023). Table 30 of the rule compares the 40th percentile MIPS quality performance category scores for PYs 2018 through 2021, using the current methodology and as projected for PY 2022, using the newly finalized methodology.

[8] This policy was finalized in the CY 2023 PFS final rule (87 FR 69858).

Selected Comments/Responses. Some commenters requested CMS provide scoring toolkits and informational resources. CMS responds it plans to provide updates to the APP Toolkit available at QPP Resource Library (cms.gov) and other educational documents for ACOs as close to the start of the performance period as possible. Several commenters requested the agency publish MIPS quality performance category scores in the Public Use Files (PUF). CMS responds that in the MSSP Performance Year Financial and Quality Results PUF it provides ACO-specific variables related to quality performance results, including the ACO's quality score, indicators for each of the three measure reporting options, an indicator whether the ACO met the quality performance standard, and an indicator whether the ACO did not completely report quality for any of the reporting options.

f. Application of a Shared Savings Program Scoring Policy for Excluded APP Measures

Background. The 2021 PFS final rule (85 FR 84720 through 84734) aligned the Shared Savings Program quality performance scoring methodology with that of the MIPS. For each quality measure that an ACO submits that has significant changes,[9] the total available achievement points are reduced by 10 points. For each MIPS measure that is submitted and impacted by significant changes, performance is based on 9 consecutive months of data of the PY. The measure is excluded from a clinician's total measure achievement points and total available measure achievement points, if data on the measures are not available or if it may result in patient harm or misleading results.

Based on this measure exclusion policy, the eCQM version of the Preventive Care and Screening: Screening for Depression and Follow-up Plan measure and the Controlling High Blood Pressure measure were excluded in PY 2022 from the MIPS measure achievement points and total available measure achievement points for the MIPS Quality performance category. If an ACO reported on one or both, its total measure achievement and total available achievement points were each reduced by 10 (or, if reporting both measures, 20) points. These ACOs were still required to report all 6 measures under the APP even though the MIPS Quality performance category score was based on only the non-excluded measures in the APP measure set.

Revisions. CMS is finalizing its proposal, beginning for PY 2024, that in the case of an ACO that reports all required measures under the APP, meets the data completeness criteria, and receives a MIPS quality performance category score that was calculated using reduced total available measure achievement points because of a measure exclusion under §414.1380(b)(1)(vii)(A) (or at least one of the eCQMs/MIPS CQMs/Medicare CQMs does not have a benchmark described in that section), in order to determine if the ACO meets the quality performance standard required to share in savings at the maximum rate under its track, the agency will apply a floor to the ACO's quality performance score. That is, under those circumstances, the ACO's quality performance score will be the higher of (i) the ACO's health equity adjusted quality performance score or (ii) the equivalent of the 40th percentile MIPS quality performance category score (across all MIPS quality performance category scores, except providers eligible for facility-based scoring).

[9] Significant changes means changes to a measure that are beyond the control of the clinician and may result in patient harm or misleading results, including changes to codes, clinical guidelines, or measure specifications.

CMS also finalizes its proposal that excluded quality measures will be unscored for calculating the health equity adjustment so that excluded measures will not cause an ACO to be ineligible for the adjustment as long as the ACO reports all required measures, meets the data completeness requirements, and receives a quality performance category score.

Selected Comments/Responses. All commenters supported the proposal to apply a Shared Savings scoring policy for excluded APP measures.

g. Require Spanish Language Administration of the CAHPS for MIPS Survey

Background. CMS has official translations of the MIPS survey in 7 languages.[10] Use of the translations is mostly voluntary. Entities that elect CAHPS for MIPS survey are required to contract with a CMS-approved survey vendor to administer the survey and need to request survey translations in order for the vendor to administer the survey in any of the optional languages.

Revisions. In section IV.A.4.f.(1)(c)(ii) of the rule, CMS finalizes its proposal to require MIPS eligible clinicians to contract with a CMS-approved survey vendor to administer the Spanish survey translation beginning with 2024 survey administration.

h. Alignment of CEHRT Requirements for Shared Savings Program ACOs with MIPS

Background. CMS describes how the Quality Payment Program (QPP), Shared Savings Program, and other quality programs require the use of certified EHR technology (CEHRT)[11] and its statutory authority to incorporate reporting requirements and payment incentives under the PFS (and QPP specifically) into the Shared Savings Program.[12] The definition of CEHRT that applies under the QPP has been applied under the Shared Savings Program.[13] ACOs are currently required to certify at the end of each performance year the following:[14]

- In the case of an ACO in a track that does not meet the financial risk standard to be an AAPM, that at least 50 percent of the eligible clinicians participating in the ACO use CEHRT; and
- In the case of an ACO in a track that meets such financial risk standard to be an AAPM, that the percent of eligible clinicians participating in the ACO that use CEHRT meets or exceeds the threshold established under the QPP (which is 75 percent).[15]

Removing CEHRT Use Threshold Requirements and Requiring Reporting of the MIPS Promoting Interoperability Performance Category. To integrate MIPS promoting interoperability (PI) category requirements under the Share Savings Program, CMS finalizes its proposal that any MIPS PI category requirements, including as changed by regulation (such as under the final rule), will also apply to MIPS eligible clinicians, QPs, and Partial QPs participating in an ACO.

[10] The translations are in Spanish, Cantonese, Korean, Mandarin, Portuguese, Russian, and Vietnamese.
[11] The Office of the National Coordinator for Health Information Technology has codified under 45 CFR part 170 standards, implementation specifications, certification criteria, and certification program for health IT.
[12] See section 1899(b)(3)(D) of the Act.
[13] The CEHRT definition under the QPP is at §414.1305 and is applied to the shared savings program at §425.20.
[14] See §425.506(f).
[15] The threshold under the QPP is at §414.1415(a)(1)(i).

The agency finalizes this policy with modification, including to delay its implementation by one year. Therefore, CMS will sunset the Shared Savings Program CEHRT threshold requirements at the end of PY 2024, and beginning with PY 2025, MIPS eligible clinicians, qualifying APM participants (QPs), and partial qualifying APM participants (partial QPs), unless otherwise excluded and regardless of track, will be required to (finalized at §425.507(a)):

- Report the MIPS PI performance category measures and requirements to MIPS[16] as (i) an individual, group, or virtual group; or (ii) the ACO as an APM entity; and
- Earn a MIPS performance category score for the PI performance category at the individual, group, virtual group, or APM entity level.

CMS is finalizing with modification at §425.507(b) that the exemptions that apply to eligible clinicians under the MIPS PI performance category requirements as set forth in 42 CFR part 414, subpart O will also apply to ACO participants, ACO providers/suppliers, and ACO professionals for the requirement under §425.507(a). However, an ACO participant, ACO provider/supplier, or ACO professional cannot be excluded from the requirements solely on the basis of being a QP or Partial QP. Applicable exclusions may include an ACO participant, ACO provider/supplier, or ACO professional who:

- Does not exceed the low volume threshold;[17]
- Is an eligible clinician who is not a MIPS eligible clinician and has opted to voluntarily report MIPS measures and activities;[18] or
- Has not earned a PI performance category score because the category has been reweighted.[19]

Table 31 of the rule contains examples of exclusions that would apply and under what circumstances.

Selected Comments and Responses Relating to CEHRT Policy. Several commenters were opposed to the policy because they believed it would increase administrative burden, especially for small practices, and discourage participation in the Shared Savings Program. In response, CMS indicates it will assess the appropriateness of exemptions based on special status and may address that in future rulemaking. The agency also points to the voluntary reporting option at the ACO level, which could alleviate individual clinician burden. Several commenters were concerned about the timeline proposed for the requirement. In response, CMS is delaying the implementation of the requirement to begin with PY 2025. Other commenters requested clarification on the consequence for an ACO if clinicians within the ACO do not meet the PI category's requirements. In response, CMS further clarifies that beginning in PY 2025, if an ACO fails to meet the requirements, the agency may take remedial action before termination for noncompliance, which includes providing a warning notice, requesting a corrective action plan from the ACO, or placing the ACO on a special monitoring plan. The agency also notes that ACO participation agreements must permit the ACO to take remedial action against the ACO participant.

[16] Requirements for reporting PI performance category measures are under 42 CFR part 414 subpart O.
[17] See the low volume threshold at §414.1310(b)(1)(iii).
[18] An eligible clinician is defined at §414.1305. The option to voluntarily submit measures and activities can be found at §414.1310(b)(2).
[19] The reweighting policy ban be found at §414.1380(c)(2).

Updating Public Reporting Requirements. CMS finalizes, with modifications, its proposal to require ACOs to publicly report the number of MIPS eligible clinicians, QPs, and partial QPs participating[20] in the ACO that earn a MIPS performance category score for the PI performance category. Those who would be excluded from the PI performance category requirements could be excluded from this count. One modification is to delay implementation (by one year) until PY 2025. Another modification is to clarify that the publicly reported number must include those who voluntarily reported and received a MIPS PI performance category score.

Updating Annual Certification Requirements. To align with the above proposals related to the MIPS PI performance category (including the sunset of the Shared Savings Program CEHRT threshold requirements), CMS finalizes to also sunset the Shared Savings Program Annual Certification requirement at §425.302(a)(3)(iii) after PY 2024, which is specific to ACO clinicians certifying their use of CEHRT. This reflects a 1-year delay from what had been proposed (i.e., sunset is now after PY 2024, instead of after PY 2023) consistent with the timing described above.

i. RFI: MIPS Value Pathway (MVP) Reporting for Specialists in Shared Savings Program ACOs

CMS believes that encouraging specialists to report on MVPs would lead to increased specialty engagement in the Shared Savings Program. Therefore, in the 2024 PFS Proposed Rule CMS solicited comment on scoring incentives that could be applied to an ACO's health equity adjusted quality performance score beginning in PY 2025 when specialists who participate in the ACO report quality MVPs. CMS is considering bonus points for ACOs with specialists reporting quality MVPs that would be applied after MIPS scoring is complete. Specialists that participate in the ACO would need to report MVPs and the ACO would need to report all measures in the APP measure set, meet the data completeness requirement, and receive a MIPS quality performance category score to be eligible for the bonus points. In addition, among other specific questions, CMS sought feedback on aligning quality measures in the Adult Universal Foundation with measures used in the MSSP. CMS does not summarize any of the comments received, but notes that it may consider the feedback received to inform future rulemaking.

j. Revisions to the Requirement to Meet the Case Minimum Requirement for Quality Performance Standard Determinations

Background. ACOs must meet the case minimum requirement (i) to determine the quality performance standard for ACOs in the first PY of their first agreement period, (ii) for the eCQM/MIPS CQM incentive for PY 2024, and (iii) for the extreme and uncontrollable circumstances policy.

Revisions. CMS finalizes several revisions and clarifications, including to language at §425.512(a)(2), (a)(5)(i)(A)(2), and (c)(3) to remove references to the case minimum requirements generally at §414.1380 and instead include language in each respective provision that clarifies the specific case minimum requirement under the specific paragraph of §414.1380 that applies in each specific circumstance (i.e., matching the requirement to the specific case of

[20] Definitions for MIPS eligible clinicians, QPs, and partial QPs can be found at §414.1305.

(i) the quality performance standard for ACOs, (ii) the eCQM/MIPS CQM incentive for PY 2024, or (iii) the extreme and uncontrollable circumstances policy).

3. Determining Beneficiary Assignment Under the Shared Savings Program

a. Modifications to the Step-Wise Assignment Methodology and Approach

Background.

Assignment Methodology. CMS reviews the evolution of beneficiary assignment to Shared Savings Program ACOs. CMS describes that "assignment" in the context of the Shared Savings Program refers to an operational process Medicare uses to determine whether a beneficiary receives a sufficient level of specified primary care services from practitioners in an ACO, indicating that the ACO qualifies as responsible for that beneficiary's care.[21]

CMS uses a step-wise assignment methodology (a 2-step claims-based process) for determining an ACO's assigned population.

- As a "pre-step," CMS identifies beneficiaries who had at least 1 primary care service furnished by an ACO professional in the ACO who is (i) a primary care physician (PCP) or (ii) a physician with a specialty designation specified in §425.402(c) (specialty designation physicians).
- Under step 1, a beneficiary eligible for assignment who satisfies the pre-step requirement is assigned to an ACO if the allowed charges for primary care services furnished to the beneficiary during the assignment window by a primary care physician, NP, PA, or CNS (primary care professionals) in the ACO are greater than the allowed changes for primary care services furnished during such window by primary care professionals not affiliated with that ACO but identified by a Medicare billing TIN.
- Under step 2, of the remaining eligible beneficiaries who satisfy the pre-step but who did not receive any primary care services during the window described in step 1 from a primary care professional, a beneficiary is assigned to the ACO if the allowed charges for the beneficiary for primary care services received during the window from an ACO professional who is a specialty designation physician are greater than those for such services received during the window from specialty designation physicians who are not associated with the ACO but are identified by a Medicare billing TIN.

An ACO may select for each performance year to use either a prospective assignment (PA) approach or preliminary prospective assignment with retrospective reconciliation (PPAR) approach. The assignment window for the PA approach is a 12-month period preceding the calendar year and for the PPAR approach is a 12-month period based on the calendar year.

CMS reviews in detail the various Shared Savings Program operations that are based on the ACO's assigned population or that consider the size of the population. It also describes the non-claims-based process for beneficiary voluntary assignment under which a beneficiary may identify an ACO professional as their PCP for purposes of assignment. Voluntary assignment supersedes any claims-based assignment.

[21] See 42 CFR part 425, subpart E for the regulations on the MSSP assignment methodology.

Identification and Uses of Assignable Population. For agreement periods beginning on or after January 1, 2024, risk-adjusted regional expenditures and the share of assignable beneficiaries assigned to an ACO are calculated using county-level values based on the assignable population identified using the assignment window approach (PA or PPAR) applied by the ACO for the given performance year.[22] CMS lists in detail the various calculations under the Shared Savings Program that use the assignable beneficiary population.

Concerns about Beneficiaries Excluded from the Current Assignment Methodology. CMS expresses concern that the assignment pre-step and definition of assignable beneficiary could prevent beneficiaries otherwise eligible for assignment from being assigned to an ACO. The agency believes that modifying the assignment methodology and broadening the definition of assignable beneficiary would lead to greater health equity.

Revisions. CMS finalizes the following proposals, without modification:

Expanded Window for Assignment. CMS finalizes its proposal, beginning with PY 2025, to add a third step to the claims-based assignment process that will use an expanded window to identify additional FFS beneficiaries for ACO assignment, as well as to change the assignable beneficiary definition to incorporate this expanded window. The expanded window for assignment will be defined as the 24-month period used to assign beneficiaries to an ACO or to identify assignable beneficiaries, and will include the 12-month assignment window (under the PA or PPAR approach, as selected by the ACO for the PY) and the previous 12 months.

Adding a Step 3 to the Assignment Methodology. Step 3 will identify Medicare FFS beneficiaries not identified under the pre-step but who (i) received at least 1 primary care service with an ACO professional who is an NP, PA, or CNS in the ACO during the 12-month assignment window, and (ii) received during the 24-month expanded window at least 1 such service with an ACO professional who is a primary care physician or specialty designation physician.

A beneficiary identified pursuant to step 3 will be assigned to an ACO if the allowed charges for primary care services furnished to the beneficiary by primary care professionals in the ACO during the expanded window are greater than the allowed charges for such services furnished by primary care professionals not affiliated with the ACO and identified by a Medicare billing TIN.

A beneficiary who is prospectively assigned to an ACO via step 3 will remain assigned to the ACO for the benchmark or performance year, unless the beneficiary meets any exclusion criteria.[23] This is the same policy currently applied for beneficiaries prospectively assigned via step 1 or 2. When the expanded window includes any month during the PHE, CMS will apply the additional primary care services codes used related to the COVID-19 PHE to all months of the expanded window. This is consistent with the current policy that applies to the assignment window.

[22] This policy was finalized in the CY 2023 PFS final rule (87 FR 69929 through 69932).
[23] Exclusion criteria may be found at § 425.401(b).

CMS reviews the following potential downstream impacts of having larger assigned populations by reason of the proposed use of step 3 with the expanded window:

- Could result in more ACOs meeting the minimum size requirements for participation.
- Would result (i) in lower minimum savings rates for ACOs subject to a variable minimum savings rate, which in turn would reflect a lower threshold ACOs would need to meet to share in savings; and (ii) in a lower minimum loss rate for ACOs in a 2-sided risk model with a variable minimum loss rate, which would reflect in a lower threshold to meet before sharing in losses.
- Would enable higher performance payment limits, which are based on a percentage of an ACO's total benchmark expenditures, and a larger loss sharing limit, which is also determined as a percentage of aggregate benchmarks.
- Could affect an ACO's revenue status since the participants' total FFS revenue would not change but the assigned population's total FFS expenditures would increase. Revenue-to-expenditure ratios would therefore decrease for ACOs with a larger assigned population.
- Could affect ACOs' average risk scores, mix of beneficiaries, regional service area, and total expenditures during benchmark and performance years.

Definition of an Assignable Beneficiary. CMS finalizes its proposal that beginning for PY 2025, the term "assignable beneficiary" will include:

- The current defined population: Medicare FFS beneficiaries who received at least one primary care service during a specified 12-month assignment window from a Medicare-enrolled physician who is a primary care physician or a specialty designation physician; and
- Additional population: Medicare FFS beneficiaries who both (i) received at least 1 primary care service from a Medicare-enrolled NP, PA, or CNS during the 12-month assignment window, and (ii) received during the 24-month expanded window at least 1 such service with a Medicare-enrolled physician who is a primary care physician or specialty designation physician.

For all ACOs (regardless of agreement period start data) for benchmark and performance year factors based on the national assignable population, CMS will identify the assignable beneficiary population, including by using the 24-month expanded window, which will include the 12-month assignment window (that is the window used for steps 1 and 2) and the preceding 12 months. CMS lists specific regulatory provisions (such as for calculating the county-level share of assignable beneficiaries, regional adjustment, and FFS expenditures) that refer to the assignment window, which it is amending to specify that the assignable population will be identified for the relevant benchmark year or performance year using the assignment window or expanded window that is consistent with the assignment methodology selected by the ACO.

CMS reviews possible downstream impacts from changing the definition. A few of those impacts are included here:

- Changes in the distribution of expenditures among the national assignable population could affect the thresholds used to truncate expenditures.
- Changes in average per capita expenditures and risk scores could affect the average risk-adjusted spending within ACOs' regional service areas, which could affect regional adjustments.

- Changes in the number of assignable beneficiaries could affect ACOs' market shares, which determine the weights used for blending the national and regional trend and update factors.
- Changes in the level of national FFS expenditures for the population could affect the caps applied to the regional adjustment and prior savings adjustment to the historical benchmark.

Simulations to Understand the Potential Effects of Proposed Changes. CMS conducted an analysis that simulated the effects of the newly finalized step 3 and revised definition of an assignable beneficiary, using 2021 as the assignment window (which results in the expanded assignment window being January 1, 2020 through December 31, 2021). Based on the current methodology, the national assignable population was a total of 26.2 million beneficiaries. Applying the newly finalized policies added 76,156 assignable beneficiaries. The group of added beneficiaries included a larger share of beneficiaries with disabled Medicare enrollment type, who resided in areas with slightly higher than average ADI national percentile rank, and had a larger share with any months of Part D LIS enrollment. The added population also included beneficiaries with a lower average HCC risk score, lower total per capita spending, higher hospice utilization, and higher mortality rate than assignable beneficiaries that would be determined without the finalized policies. Table 32 of the rule shows selected characteristics of beneficiaries added to the assignable population through the simulation.

Implementation of Revisions. CMS finalizes its proposal that the expanded window and additional step 3 for the assignment methodology will apply to all ACOs beginning for PY 2025. CMS will apply the revised approach to determining beneficiary assignment and the revised definition of assignable beneficiary in establishing, adjusting, updating, and resetting historical benchmarks for ACOs entering new agreement periods beginning on or after January 1, 2025. Benchmarks will be adjusted at the start of PY 2025 for ACOs in an agreement period other than their first agreement period.

Selected Comments/Responses. A large majority of commenters were broadly supportive of an approach that would better account for beneficiaries' primary care relationship with non-physician practitioners. About half of those commenters supported finalizing the agency's changes as proposed. Several commenters asked for further analysis by CMS of the potential impacts of the changes before finalizing the changes, including analyses on the impact to ACO benchmarks and potential changes to regional factors, and on the impact on various Shared Savings Program calculations. Concern was raised that the revisions to the definition of assignable beneficiary will have varying effects on ACO's financial performance and that rural ACOs may be disproportionately affected. CMS responds with extensive detail on further simulations it conducted after publication of the 2024 PFS Proposed Rule. It simulated the changes for both the assignable and ACO-assigned populations for PY 2019 and 2021 using the set of 364 ACOs that participated in the Shared Savings Program in both of those PYs. These simulations allowed the agency to confirm that findings from PY 2021 (affected by the PHE) were not anomalous. A comparison of the simulated impact on the assignable population for each of the two years showed similar patterns between the two years. As in the simulation described in the proposed rule, the PY 2019 group of added beneficiaries from the expanded window for the simulation was more likely to be disabled Medicare enrollees and have an ADI

national percentile rank of 85 or greater. A larger share of the beneficiaries had at least one month of Medicare Part D LIS enrollment and the added assignable beneficiaries had a lower average prospective HCC risk score, lower total per capita spending in 2021, and higher hospice utilization than those identified with the current definition of assignable beneficiary (Table 33 in the rule). Table 34 in the rule shows similar results for the simulations of the addition of step 3 to the beneficiary assignment methodology. The simulations results showed an increase in the total number of those assigned to ACOs of 2.1 percent in PY 2019 and of 2.3 percent in PY 2021. Table 35 in the rule shows the average estimated impact of the step 3 assignment simulation on ACOs' gross savings for PY 2021. CMS did not observe any meaningful differences between the financial impact of the changes among ACOs with different characteristics (i.e., rural versus urban, differences in market share, differences in size, etc.).

Many commenters raised concerns about the agency's ability to distinguish between non-physician practitioners who practice primary care and those who practice specialty care, including because of a lack of secondary specialty code designations for non-physician practitioners. However, CMS points out most non-physician practitioners have been trained in primary care or in providing services in primary care settings. The agency states that the new step 3 is designed to capture beneficiaries who receive primary care from ACOs that rely on advanced practice provider care models (i.e., those in which NPs, PAs, and CNSs collaborate with primary care physicians and other physicians with specialties used in assignment to manage their patients' primary care). CMS declines to incorporate suggestions at this time to establish additional procedures to distinguish between non-physician practitioners working as specialists from those working in primary care.

Other commenters expressed concerns that the Shared Savings Program's risk adjustment and benchmarking methodologies would not adequately account for complex and high-needs beneficiaries newly assigned to ACOs under the modifications, and therefore suggested changes to the risk adjustment and benchmarking methodologies. CMS points to the additional simulations described above, which it believes show that any downward effects on the average ACO's benchmarks as a result of the modifications in the risk profile of its population are offset by an average increase in the number of beneficiaries assigned to the ACO, allowing the ACO to earn a larger shared savings payment.

b. Revisions to the Definition of Primary Care Services used in Shared Savings Program Beneficiary Assignment

Background. CMS lists the specific HCPCS/CPT codes identified for PY 2023 and subsequent PYs as primary care services for purposes of assigning beneficiaries to ACOs. [24]

Finalized Revisions. To remain consistent with billing and coding under the PFS, CMS is finalizing its proposal to amend the definition of primary care services used in the assignment methodology to include the following additional codes and make technical changes beginning for PY 2024:

[24] Primary care services is defined in §425.402 as the set of services identified by the listed HCPCS/CPT codes.

Smoking and tobacco-use cessation counseling services CPT codes 99406 and 99407. CMS justifies adding these services because they are recognized as preventive services and therefore the agency believes they are similar to other preventive services (such as alcohol misuse screening and counseling) currently included in the definition of primary cares services for purposes of beneficiary assignment.

Cervical or Vaginal Care Screening Code HCPCS code G0101. This code can be reimbursed under Medicare Part B every 2 years or for those considered high risk on an annual basis. CMS considers these services as preventive health services that can be provided in a primary care setting, and therefore as appropriate for inclusion.

Office-Based Opioid Use Disorder Services HCPCS Codes G2086, G2087, and G2088. Bundled payments under the PFS for the overall treatment of Opioid Use Disorder (OUD), including these codes, were established in the 2020 PFS final rule (84 FR 62568) to enable counseling and care coordination in an office setting for patients with OUD. Since these codes are identified as codes for alcohol and substance abuse-related diagnoses that are excluded from the Shared Savings Program Claim and Claim Line Feeds, ACOs will not be able to see claims that have been used in assignment for those receiving these services. Since the services include overall management and care coordination activities, CMS believes they should be included.

Complex E/M Services Add-on HCPCS Code G2211, as newly finalized under section II.F. Section II.F. of the rule discusses this code in detail. Since it is used in conjunction with office/outpatient E/M services, which are included in the definition of primary care services, CMS believes it appropriate to also include this code for purposes of beneficiary assignment.

Community Health Integration (CHI) Services, finalized as HCPCS Codes G0019 and G0022. Separate coding, payment, service elements and documentation requirements for these codes are being finalized with revisions in section II.E, where they are discussed in detail. CHI services are designated as care management services. Since care management services are broadly included in the definition of primary care services used for beneficiary assignment, CMS believes these codes are appropriate for inclusion here.

Principal Illness Navigation (PIN) Services, finalized as HCPCS codes G0023 and G0024. New coding for these services is being finalized with revisions in section II.E, where they are discussed in detail. These are a set of services focused on patients with a serious, high-risk illness who may not have SDOH-related needs that would be furnished following an initial E/M visit addressing a single high-risk disease. These services are designated as care management services, which are broadly included in the definition of primary care services, and therefore CMS believes they are appropriate for inclusion here.

SDOH Risk Assessment, finalized as HCPCS code G0136. This new stand-alone code is being finalized in section II.E (where it is discussed in detail) to identify work involved in the utilization of SDOH risk assessment as part of a comprehensive social history in relation to an E/M visit. Since these services will be provided in conjunction with professional services which can be provided in a primary care setting, CMS believes they are appropriate for inclusion here.

Caregiver Behavior Management Training CPT Codes 96202 and 96203. Section II.E. of the rule (which discusses this code in more detail) finalizes an active payment status for these codes used to report face-to-face time spent by a physician or other qualified health professional in providing group training to caregivers to assist patients in carrying out the treatment plan for the patient's primary diagnosis. CMS believes these services are appropriate for inclusion since they could be billed as "incident to" by the billing practitioner who could be a primary care physician, and the services couldn't duplicate services provided in conjunction with transitional care management, chronic care management, behavioral health integration services, and virtual check-in services which are currently included in the list of primary care services used for purposes of beneficiary assignment.

Caregiver Training Services CPT codes, finalized as 97550, 97551, and 97552 in section II.E of the rule. The 3 codes are to report the face-to-face time spent by a physician or other qualified health professional providing individual or group training to caregivers aimed at improving the patient's ability to successfully perform ADLs. An active payment status for these codes is being finalized under section II.E, where they are discussed in detail. The services are to be reported to Medicare only when furnished in conjunction with treatment for particular conditions and as part of a plan of care. CMS expresses similar reasons for inclusion of these codes as stated for the proposed Caregiver Behavior Management Training codes.

Codes Not Finalized for Inclusion in Definition. Based on comments described below, CMS is not finalizing for inclusion in the definition the remote physiologic monitoring CPT codes 99457 and 99458.

Selected Comments/Responses. Most commenters were supportive of adding the following (described above) to the definition of primary care services used in assignment: (1) Smoking and Tobacco-use Cessation Counseling Services; (2) Cervical or Vaginal Cancer Screening; (3) Complex E/M Services Add-on; (4) CHI services; (5) PIN services; (6) Caregiver Behavior Management Training; (7) Caregiver Training Services; and (8) SDOH Risk Assessment. Several commenters were concerned that many of the codes proposed to be added would be new codes to the 2024 PFS and encouraged CMS to conduct additional analysis on the impact of the policy before finalizing it or a phase-in of the policy. CMS responds it is important for beneficiary assignment that the definition of primary care services be consistent and up-to-date with billing and coding updates. Some commenters were concerned with the addition of certain codes, such as for cervical or vaginal cancer screening, because they believe the code would shift assignment to specialty care. The agency states that if a service is provided by specialists not considered for purposes of beneficiary assignment, then the service will not be considered as a primary care service in such assignment. For the example of the cervical or vaginal cancer screening services, CMS responds the services can be provided in a primary care setting and that obstetrics/gynecology and gynecology/oncology are identified as physician specialty designations considered for purposes of identifying primary care services for assignment purposes.

Some commenters supported the proposal to include the remote physiologic monitoring (RPM) codes, but many recommended these codes not be included. Reasons in opposition included the significant rise in its utilization by medical specialties, the potential for disincentivizing some

practitioners from ordering these services, and concern that the codes can be billed by primary care providers and specialists (yet can only be billed by one treating provider per patient). CMS agrees with these concerns raised and therefore is not finalizing inclusion of CPT codes 99457 and 99458 for RPM services, stating that inclusion of the codes could inappropriately impact the determination of where a beneficiary received a plurality of their primary care services. However, CMS clarifies that these services will still be reflected in the calculation of expenditures for ACO-assigned beneficiaries for each benchmark year and performance year.

4. Benchmarking Methodology

a. Overview

In this section of the final rule, CMS finalizes modifications to the benchmarking methodology under the Shared Savings Program. It states that its policies are aimed at encouraging sustained participation by ACOs in the program. Specifically, CMS:

- Modifies the existing calculation of the regional update factor used to update the historical benchmark between benchmark year (BY) 3 and the performance year.
- Further mitigates the impact of the negative regional adjustment to the historical benchmark.
- Refines the prior savings adjustment calculation methodology for renewing ACOs and re-entering ACOs entering an agreement period beginning on January 1, 2024, and in subsequent years.
- Updates how benchmarks are risk-adjusted by using the CMS-HCC risk adjustment model.

b. Cap Regional Service Area Risk Score Growth for Symmetry with ACO risk Score Cap

(1) Background

CMS reviews how the incorporation of a regional growth risk factor in the benchmark calculation has evolved since it was first established in the June 2016 final rule (81 FR 37977 through 37981). Most recently in the 2023 PFS final rule, it finalized a policy for agreement periods starting on or after January 1, 2024, under which it will update the historical benchmark between BY3 and the performance year for each year of the agreement period using a three-way blend calculated as a weighted average of a two-way blend of national and regional growth rates determined after the end of each performance year and a fixed projected growth rate determined at the beginning of the ACO's agreement period called the Accountable Care Prospective Trend (ACPT) (§425.652(b)). Under this policy, CMS makes separate calculations for expenditure categories for each Medicare enrollment type. CMS believed that incorporating this prospective trend in the update to the benchmark insulates 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 addresses the impact of increasing market penetration by ACOs in a regional service area on the existing blended national-regional growth factor.

ACOs and other interested parties, however, continue to express concern that the program's current cap on ACO risk score growth between BY3 and the performance year does not account for risk score growth in the ACO's regional service area and that there is not an equivalent cap on regional risk score growth. High prospective HCC risk score growth in an ACO's regional service area between BY3 and the performance year has the effect of decreasing the regional update factor, resulting in a lower updated benchmark for the ACO than if the regional risk score growth were capped (assuming that the risk score growth was high enough to be capped).

(2) Revision

CMS finalizes its proposal to revise the Shared Savings Program regulations governing the calculation of the regional growth rate when updating the historical benchmark between BY3 and the performance year at §425.652(c) to incorporate a regional risk score growth cap adjustment factor. It also adds a new section to the regulations at §425.655 to describe the calculation of the adjustment factor. The changes to the calculation of the regional component of the update factor is applicable for agreement periods beginning on or after January 1, 2024.

CMS provides a detailed description in the preamble on how the regional risk score growth cap adjustment factor is calculated (pages 1084-1088 in the display copy). The five steps are briefly described here:

Step 1: *Calculate county-level risk scores.* CMS calculates county-level prospective HCC and demographic risk scores by Medicare enrollment type for both BY3 and the performance year.

Step 2: *Calculate regional risk scores.* CMS calculates regional-level BY3 and performance year prospective HCC and demographic risk scores as a weighted average of county-level HCC and demographic risk scores for the Medicare enrollment type (calculated in step 1), with weights reflecting the proportion of the ACO's assigned beneficiaries in the county.

Step 3: Determine aggregate growth in regional risk scores. To calculate aggregate growth in regional risk scores, CMS first calculates growth in prospective HCC and demographic risk scores between BY3 and the performance year for each Medicare enrollment type, expressed as the ratio of the performance year regional risk score for a Medicare enrollment type (calculated in step 2) to the BY3 regional risk score for that enrollment type (calculated in step 2). It next takes a weighted average of the regional prospective HCC or demographic risk ratios, as applicable, across the four Medicare enrollment types, where the weight applied to the growth in risk scores for each Medicare enrollment type is the ACO's performance year assigned beneficiary person years for the Medicare enrollment type multiplied by the ACO's regionally adjusted historical benchmark expenditures for the Medicare enrollment type.

Step 4: Determine the cap on regional risk score growth. CMS first calculates the non-market share adjusted cap on the ACO's regional risk score growth as the sum of the aggregate growth in regional demographic risk scores (calculated in step 3) and 3 percentage points. It next adjusts the cap to reflect the ACO's aggregate market share.

Step 5: Determine the regional risk score growth cap adjustment factor. First, CMS determines if the ACO's regional risk score growth is subject to a cap by comparing the ACO's aggregate

regional prospective HCC risk score growth (calculated in step 3) to the market share adjusted cap on regional risk score growth (calculated in step 4).

++ If the aggregate regional prospective HCC risk score growth does not exceed the cap on regional risk score growth, the ACO's regional risk score growth is not subject to the cap. For these ACOs CMS sets the risk score growth cap adjustment factor equal to 1 for each Medicare enrollment type (which is effectively no adjustment).

++ If the aggregate regional prospective HCC risk score growth exceeds the market share adjusted cap, the ACO's regional risk score growth is subject to the cap. For these ACOs CMS next determines whether the cap on regional risk score growth applies for each Medicare enrollment type.

Table 37 in the final rule provides an example of the calculation of the regional risk score growth cap adjustment factor for a hypothetical ACO that is determined to be subject to the market share adjusted cap.

CMS simulated the impact of the policy using PY 2021 financial reconciliation data for ACOs in agreement periods beginning on or after July 1, 2019. This simulation found that 38 of the 332 ACOs (11 percent) would have been subject to the cap on regional risk score growth determined in step 4 of the methodology and therefore would have had a higher regional update factor than under current policy for at least one Medicare enrollment type. Thirty-six of those 38 ACOs were subject to the 3 percent cap on their own risk score growth for at least one enrollment type in actual PY 2021 results. It notes that while its modeling shows that only a small proportion of ACOs would have benefitted from this policy in PY 2021, its analyses have also shown that this proportion is predicted to increase as more ACOs advance further into their 5-year agreement period.

Most commenters supported the overall proposal to cap regional service area risk score growth for symmetry with the ACO risk score cap. One of the primary reasons for support included the positive effect the policy would have on ACOs that care for underserved beneficiaries or medically complex, high-risk beneficiaries as it would bolster the financial stability of ACOs caring for that population. MedPAC also supported the proposal to cap regional risk score growth with an adjustment for an ACO's market share stating that the proposal reasonably protects ACOs from coding that may be out of their control, depending on an ACO's share of the market. MedPAC believes, however, that it should be viewed as an interim step because it does not address the underlying issues with coding incentives and regional benchmarking. CMS agrees and believes this policy would encourage participation by ACOs in regions with changing beneficiary demographics and health status beyond the ACO's control and it agrees with commenters that it would incentivize ACOs to care for higher risk beneficiaries.

c. Mitigating the Impact of the Negative Regional Adjustment on the Benchmark to Encourage Participation by ACOs Caring for Medically Complex, High-Cost Beneficiaries

(1) Background

In the 2023 PFS final rule (87 FR 69915 through 69923), CMS finalized several policies intended to reduce the impact of negative regional adjustments for agreement periods beginning on January 1, 2024, and subsequent years. These changes included the following:

- Replaced the negative 5 percent cap on the negative regional adjustment with a negative 1.5 percent cap.
- Applied an offset factor (after applying the negative 1.5 percent cap) that would gradually decrease the negative regional adjustment amount for a given Medicare enrollment type as an ACO's proportion of dually eligible Medicare and Medicaid beneficiaries increases or its weighted average prospective HCC risk score increases.
- Offset the regional adjustment further by the prior savings adjustment for an ACO eligible for the prior savings adjustment for which the regional adjustment expressed as a single value is negative.

CMS also notes under a separate policy, also finalized in the 2023 PFS final rule, an ACO beginning an agreement period on January 1, 2024, and in subsequent years that is a renewing or re-entering ACO may be eligible to receive an adjustment to its benchmark to account for savings generated in performance years that correspond to the benchmark years of its new agreement period.[25] These policies combined were intended to incentivize ACOs that serve high-cost beneficiaries to join or continue to participate in the Shared Savings Program. In this section, CMS reviews and provides detail on how the current approach is calculated.

CMS now believes that it is important and timely to revisit this policy and to further mitigate the impact of the negative regional adjustment for ACOs with high-cost populations, thereby resulting in higher benchmarks for ACOs compared to the recently finalized methodology. In particular, CMS believes that eliminating the possibility that an ACO will receive an overall negative regional adjustment to its benchmark in combination with the other elements of the benchmarking methodology finalized in the 2023 PFS final rule would work together to further its efforts to ensure sustainability of the benchmarking methodology. It believes this policy change would further encourage continued participation among high-cost ACOs that serve medically complex beneficiaries by eliminating the potential of a lower benchmark due to an overall negative regional adjustment. It also believes that eliminating overall negative regional adjustments could further incentivize greater participation among ACOs whose ACO participants have historically been less efficient than other providers and suppliers in their regions. Such ACOs may have the greatest potential to generate cost savings for the Medicare Trust Funds.

[25] A full discussion of this policy can be found in that earlier rulemaking (87 FR 69899 through 69915).

(2) Revisions

In light of these considerations, CMS finalizes its proposal to modify the policies it adopted in the 2023 PFS final rule to prevent any ACO from receiving an adjustment that would cause its benchmark to be lower than it would have been in the absence of a regional adjustment. This modified approach applies for ACOs in agreement periods starting on January 1, 2024, and in subsequent years. CMS continues to generally calculate the adjustment as finalized in the 2023 final rule, but modifies its calculation based on whether the ACO's regional adjustment amount (expressed as a single per capita value) is positive or negative. Specifically, CMS follows this approach:

- If the ACO's regional adjustment amount is positive, the ACO receives a regional adjustment, according to the approach CMS finalized in the 2023 PFS final rule.
- If the ACO's regional adjustment amount is negative, the ACO receives no regional adjustment to its benchmark for any enrollment type. If the ACO is eligible for a prior savings adjustment, it receives the prior savings adjustment as its final adjustment, without any offsetting reduction for the negative regional adjustment.

Under this approach, ACOs that face a negative overall adjustment to their benchmark based on the methodology adopted in the 2023 PFS final rule would benefit, as they would now receive no downward adjustment. Additionally, ACOs that have a negative regional adjustment amount (expressed as a single value) and are eligible for prior savings adjustment would also be expected to benefit from the policy. Specifically, these ACOs could receive a larger positive adjustment to their benchmark or a positive adjustment instead of a negative adjustment, as CMS would no longer offset the prior savings amount by the negative regional adjustment amount when determining the final adjustment. This makes the prior savings adjustment more favorable, particularly for ACOs serving high-risk populations. CMS states that, importantly, no ACO would be made worse off under this policy.

Tables 42 and 43 in the final rule present hypothetical examples to demonstrate how CMS calculates the final adjustment to an ACO's benchmark under this policy. The prior savings adjustment is included for the example displayed in Table 42. In its simulation of using performance year 2022 data, CMS found that 26 ACOs would have had a negative regional adjustment. Fourteen of these ACOs would not have been eligible for a prior savings adjustment and would have their full negative regional adjustment eliminated with an average impact of $66. The remaining 12 ACOs would have been eligible for prior savings adjustment but would see a larger positive adjustment under the policy, with an average increase of $14.

CMS implements the changes described in this section through revisions to §§425.652, 425.656, and 425.658. It made some minor non-substantive modifications to introductory text in certain provisions from the proposed rule for improved clarity and to ensure consistency of terminology across provisions. It also makes conforming changes in other sections.

Most commenters supported the proposal to further mitigate the impact of negative regional adjustment to the benchmark. They believe the policy would increase program participation among ACOs with higher costs than their region by removing disincentives or barriers to entry,

and would encourage more ACOs to care for underserved, medically complex and high-cost patients. MedPAC indicated that they concurred with CMS' proposal but continue to express general concerns about the regional adjustment overall. CMS agrees with the commenters and believes that this policy will facilitate participation of ACOs and that it will help promote agency goals of promoting health equity and 100 percent of beneficiaries with Original Medicare in an accountable care relationship by 2030.

d. Modifications to the Prior Savings Adjustment

(1) Background

Under section 1899(d)(1)(B)(ii) of the Act, an ACO's benchmark must be reset at the start of each agreement period using the most recent available 3 years of expenditures for Parts A and B services for beneficiaries assigned to the ACO. The Secretary has statutory discretion to adjust the historical benchmark. Pursuant to this authority, as described in the 2023 PFS final rule (87 FR 69898 through 69915), CMS established a prior savings adjustment that will apply when establishing the benchmark for ACOs entering a second agreement period beginning on January 1, 2024, or in subsequent years, to account for the average per capita amount of savings generated during the ACO's prior agreement period.

The prior savings adjustment adopted in the 2023 PFS final rule is designed to adjust an ACO's benchmark to account for the average per capita amount of savings generated by the ACO across the 3 performance years prior to the start of its current agreement period for new and renewing ACOs. CMS believes that reinstituting a prior savings adjustment would help to mitigate the rebasing ratchet effect on an ACO's benchmark by returning to an ACO's benchmark an amount that reflects its success in lowering growth in expenditures while meeting the program's quality performance standard in the performance years corresponding to the benchmark years for the ACO's new agreement period.

In the 2023 PFS rulemaking, CMS did not describe how it would account for certain circumstances where there could be changes to the values used in calculating the prior savings adjustment. Such changes could occur as a result of changes in savings earned by ACOs in accordance with a corrective action plan or as a result of a compliance action to address avoidance of at-risk beneficiaries or issuance of a revised initial determination of financial performance. It may also determine that the amount of shared savings due to the ACO or the amount of shared losses owed by the ACO has been calculated in error and may reopen its prior determination and issue a revised initial determination in the case of fraud or similar fault. In the 2023 PFS rulemaking CMS did not adopt a mechanism to account for these changes in the prior savings adjustment.

(2) Revisions

CMS finalizes its proposed refinements, without modification, to the prior savings adjustment calculation methodology, specified in 42 CFR part 425, subpart G, that will apply in the establishment of benchmarks for renewing ACOs and re-entering ACOs entering an agreement period beginning on January 1, 2024, and in subsequent years, to account for circumstances

where the amount of savings or losses for a performance year used in the prior savings adjustment calculation changes retroactively. Specifically, CMS modifies the list of circumstances for adjusting the historical benchmark in §425.652(a)(9) to include two additional scenarios:

- Change in savings earned by an ACO in a benchmark year in accordance with §425.316(b)(2)(ii)(B) or (C) due to compliance action to address avoidance of at-risk beneficiaries; or
- Change in the amount of savings or losses for a benchmark year as a result of a reopening of a prior determination of ACO shared savings or shared losses and the issuance of a revised initial determination under §425.315.

In these situations, the amount of savings or losses that an ACO may have generated in the 3 performance years prior to the start of the current agreement period and that would have been eligible for inclusion in the calculation of the prior savings adjustment may change. The refinements allow for the prior savings adjustment to be recalculated and the historical benchmark to be adjusted to reflect any change in the amount of savings earned or losses incurred by the ACO in those 3 performance years.

This requires CMS to make several modifications to its regulations.

- Modification of the process currently described in §425.652(a)(9) for adjusting the historical benchmark.
- Modification of §425.652(a)(9) to indicate that an ACO receive an adjusted historical benchmark for changes in values used in benchmark calculations in accordance with §425.316(b)(2)(ii)(B) or (C) due to compliance action to address avoidance of at-risk beneficiaries or as a result of issuance of a revised initial determination under §425.315.
- Modification of the process currently described in §425.652(a)(9) to indicate that if either of these two conditions occur after the ACO has already received its historical benchmark for the first performance year of its agreement period, an ACO could receive an adjusted historical benchmark for the first year of its agreement period.
- Addition of a new paragraph (e) to §425.658 to indicate that, when either of the two aforementioned scenarios occurs, the prior savings adjustment itself is recalculated. Without this addition there is currently no mechanism for recalculating the prior savings adjustment to address changes in ACO's savings or losses for a performance year within an agreement period.
- Absent any other triggers for receiving an adjusted benchmark, an ACO receives an adjusted historical benchmark following recalculation of the prior savings adjustment if the recalculation of the prior savings adjustment did not result in a change to the historical benchmark.

CMS believes that in order to issue adjusted benchmarks and complete financial reconciliation in a timely fashion, a need exists to establish a timing cutoff for when the determination to issue an adjusted historical benchmark for these two additional reasons would be made. CMS finalizes that for an adjusted benchmark due to the two conditions being considered to be used in financial

reconciliation for a performance year, any determination that changes the amount of the ACO's savings or losses in any of the benchmark years must be issued no later than the date of the initial determination of shared savings or shared losses through financial reconciliation for the relevant performance year. Under this framework, changes to savings or losses for a benchmark year that are finalized after notification to the ACO of the initial determination of shared savings or shared losses for a given performance year will be reflected in the adjusted benchmark applied to the subsequent performance year during the relevant agreement period but will not be retroactively applied to completed performance years in the agreement period.

All comments supported the proposed changes, with several noting that the proposed policy increases program integrity without imposing undue burden on ACOs.

e. Update How Benchmarks Are Risk Adjusted

(1) Overview of Risk Adjustment within Shared Savings Program Benchmark Calculations

When establishing, adjusting and updating an ACO's historical benchmark, CMS makes certain adjustments to account for the severity and case mix of, and certain demographic factors for, the ACO's assigned beneficiary population and the assignable beneficiary population. It uses prospective HCC risk scores and (as applicable) demographic risk scores to perform this risk adjustment.

CMS reviews the calculations in which it will account for the severity and case mix of the ACO's assigned beneficiary population or the assignable beneficiary population when establishing, adjusting and updating the historical benchmark, for agreement periods beginning on January 1, 2024, and in subsequent years. These are discussed in detail in this section and include, for example, risk adjustment of benchmark year expenditures used to establish the historical benchmark for changes in severity and case mix using prospective HCC risk scores.

(2) Background on Calculation of Prospective HCC Risk Scores Used to Risk Adjust Shared Savings Program Benchmark Calculations.

CMS reviews how it has used risk adjustment models in its methodology. CMS notes that on March 31, 2023, CMS released the Announcement of 2024 MA Capitation Rates and Part C and Part D Payment Policies,[26] which finalized the transition to a revised CMS-HCC risk adjustment model. The revised 2024 CMS-HCC risk adjustment model, Version 28 (V28), has the same structure as the 2020 CMS-HCC risk adjustment model currently used for payment in that it has eight model segments as first implemented for payment for 2017 and condition count variables as first implemented for payment for 2020.

It incorporates the following technical updates: (1) updated data years used for model calibration, (2) updated denominator year used in determining the average per capita predicted expenditures to create relative factors in the model, and (3) a clinical reclassification of the hierarchical condition categories (HCCs) using the International Classification of Diseases, Tenth Revision,

[26] For more details, refer to Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (March 31, 2023) (herein CY 2024 Rate Announcement), available at https://www.cms.gov/files/document/2024-announcement-pdf.pdf

Clinical Modification (ICD-10-CM) codes. In addition, as part of the clinical reclassification, CMS conducted an assessment on conditions that are coded more frequently in MA relative to FFS. As a result of this assessment, in addition to the technical updates, the revised model includes additional constraints and the removal of several HCCs in order to reduce the impact on risk score variation in coding between MA and FFS.

For 2024, MA risk scores will be calculated as a blend of 67 percent of the risk scores calculated under the 2020 CMS-HCC risk adjustment model, Version 24 (V24), and 33 percent of the risk scores calculated with the 2024 CMS-HCC risk adjustment model (V28). CMS expects that for 2025, MA risk scores will be calculated using a blend of 33 percent of the risk scores calculated with V24 and 67 percent of the risk scores calculated with V28, and for 2026, 100 percent of risk scores will be calculated with V28.

With the transition to the use of the V28 CMS-HCC model beginning in 2024 in MA, CMS notes that it is timely to revisit how it applies the CMS-HCC risk adjustment model(s) to calculate risk scores used in Shared Savings Program calculations.

(3) Initial Analysis of the Impact of Risk Adjustment Model Changes on Shared Savings Program Calculations and Modeling of an Alternative Approach to Calculating Benchmark Year Risk Scores

To further evaluate the potential impact of the V28 CMS-HCC model transition on Shared Savings Program ACOs, CMS analyzed the following:

- Current approach in which CMS applies the CMS-HCC risk adjustment model(s) applicable for a particular calendar year to calculate a Medicare FFS beneficiary's prospective HCC risk score for the corresponding benchmark or performance year. This approach could lead to different CMS-HCC risk adjustment models being used in the methodology.
- An alternative approach in which CMS would use the CMS-HCC risk adjustment model(s) applicable to the calendar year corresponding to the performance year to calculate a Medicare FFS beneficiary's prospective HCC risk score for the performance year and for each benchmark year of the ACO's agreement period. This approach ensures consistency between the CMS-HCC risk adjustment methodology used to calculate the prospective HCC risk scores for the benchmark years relative to a particular performance year.

CMS conducted an analysis calculating prospective HCC risk scores and risk ratios for 2018 (treated as BY3) and 2021 (treated as the PY) for all 275 ACOs that participated in both PY 2018 and PY 2021. Risk ratios between BY3 and the PY were calculated under the current approach, in which CMS used the V24 CMS-HCC model to calculate BY3 prospective HCC risk scores and the V28 CMS-HCC model to calculate PY prospective HCC risk scores, and under the alternative approach of calculating both BY and PY prospective HCC risk scores using V28.

CMS found that on average ACOs would have earned roughly 0.2 percent in additional PY 2021 shared savings payments relative to the benchmark when both benchmark year and performance year prospective HCC risk scores are calculated under V28 compared to calculations under both

V24 and V28. Table 44 in the final rule compares the estimated impact on PY 2021 shared savings of the current approach and the alternative approach to calculating BY3 and PY prospective HCC risk scores.

Table 45, reproduced below, compares the estimated impact on PY 2021 shared savings of the current approach, and the alternative approach to calculating BY3 and PY risk scores (expressed as percentage of benchmark), by certain ACO characteristics. CMS observed that the current approach would have the greatest adverse effect on ACOs with the highest average risk scores (calculated with the V24 CMS-HCC model), ACOs participating in two-sided models, and ACOs that have been in the Shared Savings Program longer. For ACOs with the highest average risk scores, the modeling showed the current approach would have resulted in reduced shared savings of about 2 percent (relative to benchmark) per ACO, as compared to the alternative approach.

Table 45 Estimated Impacts on PY 2021 Shared Savings of the V28 CMS-HCC Model under Current and Alternative Approaches to BY3 and PY Risk Score Calculation, Based on ACO Characteristics (Expressed as Percent of Benchmark)

	Current Approach BY3 V24, PY V28	Alternative Approach BY3 V28, PY V28	Current minus Alternative
Average HCC (Aged/Disabled)			
>1.20	-2.0%	0.0%	-2.1%
1.10 to 1.20	-0.5%	-0.1%	-0.4%
1.025 to 1.10	-0.4%	0.0%	-0.4%
0.975 to 1.025	-0.1%	0.1%	-0.2%
0.90 to 0.975	0.2%	0.2%	0.1%
<0.90	0.5%	0.2%	0.3%
PY21 Track/Level			
Two-sided Model	-0.5%	0.0%	-0.5%
One-sided Model	0.1%	0.1%	0.0%
Program Entry			
On/before 2013	-0.6%	0.1%	-0.7%
On/after 2014	-0.1%	0.1%	-0.1%

(4) Revisions

CMS finalizes its proposal to use the CMS-HCC risk adjustment model(s) applicable to the calendar year corresponding to the performance year to calculate a Medicare FFS beneficiary's prospective HCC risk score for the performance year, and for each benchmark year of the ACO's agreement period. Under this approach, there is no potential for distortion from using different CMS-HCC risk adjustment models. This is applicable to agreement periods beginning on January 1, 2024, and in subsequent years. These provisions are set forth in at §425.659.

It believes this policy addresses the concerns of ACOs and other interested parties regarding the transition to the V28 CMS-HCC model or other similar future changes to the CMS-HCC risk adjustment methodology that could occur during the term of an ACO's agreement period. Under this policy, both the numerator and denominator in the PY/BY3 risk ratio are calculated using a consistent risk model, and any distributional impacts should, on average, be balanced. This policy does not affect how prospective HCC risk scores are calculated for ACOs in agreement periods that began prior to January 1, 2024, consistent with its historical practice of incorporating changes to the benchmarking methodology only at the start of an ACO's agreement period.

Specifically, for an ACO beginning a new agreement period on January 1, 2024, in PY1 (2024) all benchmark year and PY1 prospective HCC risk scores will be calculated using a blend of 67 percent V24 CMS-HCC model and 33 percent V28 CMS-HCC model. In PY2 (2025), all benchmark year and PY2 prospective HCC risk scores are expected to be calculated using a blend of 33 percent V24 and 67 percent V28. In PY3 (2026), all benchmark year and performance year prospective HCC risk scores are expected to be calculated using V28. In the case of an ACO in an existing agreement period that early renews for a new agreement period beginning on January 1, 2025, the calculations described in this paragraph regarding the blend of V24 and V28 for 2025 and the fully phased-in V28 CMS-HCC model for 2026 will be expected to apply for the ACO's first and second performance years (respectively).

Several commenters expressed general support for and appreciation of the proposed changes to how risk adjustment is performed for purposes of benchmark calculations. They believe that using a consistent risk score model for both benchmark years and the performance year will improve predictability in risk scores as well as prevent distortion to an ACO's historical benchmark. Many commenters supported the proposed changes but urged CMS to apply the changes to all ACOs and not just to ACOs in agreement periods beginning on or after January 1, 2024. CMS notes in its reply that ACOs have the option to "early renew" for PY 2025, meaning to terminate their current participation agreement under §425.220 and immediately enter a new agreement period to continue participation in the Shared Savings Program.

5. Modifications to Advance Investment Payment Policies

a. Overview

In the 2023 PFS final rule (87 FR 69782 through 69805), CMS finalized a new payment option for eligible Shared Savings Program ACOs entering agreement periods beginning on or after January 1, 2024, to receive advance shared savings payments. This payment option is referred to as advance investment payments (AIP) and the payments themselves are referred to as advance investment payments.

Within this section, CMS finalizes its proposed modifications to refine AIP policies to better prepare for initial implementation of AIP beginning with ACOs entering agreement periods on January 1, 2024. This includes the following policies:

- Allow ACOs to advance to two-sided model levels within the BASIC track's glide path beginning in PY3 of the agreement period in which they receive advance investment payments.

- Recoup advance investment payments from shared savings for ACOs that wish to early renew to continue their participation in the Shared Savings Program.
- Terminate advance investment payments for future quarters to ACOs that elect to terminate their participation in the Shared Savings Program.
- Require ACOs to report spend plan updates and actual spend information to CMS in addition to publicly reporting such information.
- Codify that ACOs receiving advance investment payments may seek reconsideration review of all payment calculations.

These policies are effective beginning January 1, 2024.

b. Modify AIP Eligibility Requirements to Allow ACOs to Advance to Performance Based Risk During the 5-Year Agreement Period

(1) Background

The policies CMS finalized with the 2023 PFS final rule require an ACO to remain under a one-sided model for the duration of its agreement period in which it receives advance investment payments to remain compliant with AIP requirements. The ACO would otherwise face potential compliance action and may be required to repay all advance investment payments within 90 days of receiving written notification from CMS. CMS believes this limits an ACO's ability to select participation options that include progression along the BASIC track's glide path to a performance-based two-sided risk model.

(2) Revisions

CMS finalizes its proposal to modify AIP eligibility requirements to allow an ACO receiving advance investment payments to transition to two-sided risk within its 5-year agreement period under the BASIC track's glide path. Specifically, it modifies §425.630(b)(2) and (3) to allow an eligible ACO receiving advance investment payments to advance to performance-based risk (by advancing from Level A or B to Level C, D, or E of the BASIC track's glide path) beginning in PY3 of the ACO's agreement period. It also modifies §425.316(e)(2) to specify that CMS cease payment of advance investment payments if CMS determines that an ACO approved for AIP became experienced with performance-based risk Medicare ACO initiatives during the first or second performance year of its agreement period or became a high revenue ACO during any performance year of the agreement period in which it received advance investment payments. CMS also modifies §425.316(e)(2)(i) to specify that CMS will cease payment of advance investment payments no later than the quarter after the ACO became experienced with performance-based risk Medicare ACO initiatives or became a high revenue ACO.

Under this modification to its policy, CMS would continue to recoup from future shared savings and the ACO would not be immediately obligated to repay all advance investment payments it received by virtue of its transition to a two-sided model in its third performance year or any subsequent performance year. CMS notes that under its policy if an ACO opts to progress to a two-sided risk model (BASIC track's glide path Levels C through Level E) in PY2, CMS would terminate the ACO's advance investment payments, the ACO may be subject to compliance actions and CMS may seek repayment of advance investment payments.

Commenters largely supported CMS' proposal to allow ACOs receiving advance investment payments to progress along the glide path and move into a two-sided risk model beginning in PY 3 of the ACO's agreement period. Other commenters requested that CMS further modify AIP eligibility requirements to include ACOs who have been designated as experienced with performance based risk by participating in the ENHANCED track. Some requested that CMS consider exceptions that would allow FQHCs, RHCs, and critical access hospitals (CAHs) to be eligible for AIP, even if they do not meet the current eligibility requirements regarding revenue and risk experience. In reply, CMS disagrees with commenters that it needs to further modify the AIP eligibility requirements. It does not believe that it would be appropriate to provide advance investment payments to an ACO that has been designated as experienced with performance-based risk Medicare ACO initiatives. They also disagree that revising the AIP eligibility criteria is necessary for FQHCs, RHCs, and CAHs to receive advance investment payments. It notes that the vast majority of FQHCs and RHCs participating in the program without a hospital are in low revenue ACOs, so the AIP eligibility criteria should not preclude them from receiving advance investment payments.

c. Modifications to AIP Recoupment and Recovery Policies for Early Renewing ACOs

(1) Background

In the 2023 PFS final rule, CMS finalized program policies regarding recoupment and recovery of advance investment payments. In accordance with §425.630(g)(4), if an ACO terminates its participation agreement during the agreement period in which it received an advance investment payment, the ACO must repay all advance investment payments it received. CMS will provide written notification to the ACO of the amount due and the ACO must pay such amount no later than 90 days after the receipt of such notification.

In developing the AIP policies in the PFS rulemaking for 2023, CMS did not address the potential interactions between the policy on recovery of advance investment payments and a voluntary termination of the participation agreement by an ACO that is seeking to early renew.

(2) Revisions

CMS finalizes its proposal to amend §425.630(g)(4) to create a limited exception to CMS' policy of recovering advance investment payments from an ACO that voluntarily terminates its participation agreement for the agreement period during which it received advance investment payments. Under this policy, CMS will not seek to collect all advance investment payments received from an ACO if the ACO voluntarily terminates its participation agreement at the end of PY2 or later during the agreement period in which it received advance investment payments, provided that the ACO immediately enters into a new participation agreement with CMS under any level of the BASIC track's glide path or the ENHANCED track. Rather, CMS will carry forward any remaining balance of advance investment payments owed by the early renewing ACO into the ACO's new agreement period.

CMS also finalizes its proposal to amend §425.630(e)(3) to permit an early renewing ACO to spend advance investment payments in its second agreement period so long as the advance investment payments are spent within 5 performance years of when it began to receive advance investment payments. If the ACO does not spend all of the advance investment payments received by the end of the fifth performance year, the ACO must repay any unspent funds to CMS.

CMS believes these policies would be most relevant to an ACO that is receiving advance investment payments and seeks to early renew to enter a new participation agreement to participate under modified Shared Savings Program policies that are not applicable to the ACO's current agreement period. This allows an ACO to continue its participation in the Shared Savings Program without a lapse in participation.

Most commenters were supportive of CMS' proposals to allow ACOs that receive advance investment payments to early renew but some made recommendations for refinements. This included urging CMS to consider a longer time period for recoupment of advance investment payments. CMS disagrees with commenters that a longer recoupment period would be appropriate as it views its recoupment policy as a critical measure necessary to ensure the adequate protection of the Medicare Trust Funds.

d. Require ACOs to Report to CMS Spend Plan Updates and Use of Advance Investment Payments

In the 2023 PFS final rule, CMS finalized program policies to require ACOs that receive advance investment payments to submit a spend plan to CMS as a part of their Shared Savings Program application. CMS may review an ACO's spend plan at any time and require the ACO to modify its spend plan to comply with the spend plan requirements and the requirements for use and management of advance investment payment. It also finalized requirements at §425.308(b)(8) that an ACO receiving advance investment payments must publicly report information, updated annually, about the ACO's use of advance investment payments for each performance year, including the following:

- The ACO's spend plan.
- The total amount of any advance investment payments received from CMS.
- An itemization of how advance investment payments were spent during the year, including expenditure categories, the dollar amounts spent on the various categories, any changes to the spend plan submitted under §425.630(d), and such other information as may be specified by CMS.

These provisions do not require an ACO to submit this same information to CMS.

To support CMS' ability to monitor AIP efficiently, CMS finalizes its proposal that an ACO must report to CMS the same information about its use of advance investment payments that it is required to publicly report. It adds a new provision at §425.630(i) specifying that an ACO must (1) publicly report information about the ACO's use of advance investment payments for each performance year; and (2) in a form and manner and by a deadline specified by CMS, report to CMS the same information it is required to publicly report.

CMS believes that these changes will impose little to no administrative burden on participating ACOs, which are already required to publicly report this information. Further, CMS expects to use the submitted data as the template that ACOs can use to populate their public reporting webpage early in each performance year to minimize administrative burden for ACOs.

These changes are effective January 1, 2024.

Most commenters were supportive of the proposed policy but some cautioned CMS to consider ways to reduce any extra reporting steps and instead allow for increased flexibility for reporting on advance investment payments and AIP spend plans.

e. Permitting Reconsideration Review of Quarterly Payment Calculations

In the 2023 PFS final rule, CMS specified that an ACO can request a reconsideration review if CMS does not make an advance investment payment to the ACO. However, it did not specify that an ACO could request reconsideration of the advance investment payment amount received.

CMS finalizes its proposal to permit an ACO to request a reconsideration review for all advance investment payment quarterly payment calculations, not just instances where no payments are distributed. It revises §425.630(f) to provide that CMS notify in writing each ACO of its determination of the amount of advance investment payment it will receive and that such notice inform the ACO of its right to request reconsideration review in accordance with the procedures specified under subpart I of the regulations.

All commenters supported CMS' proposed policy refinement.

6. Shared Savings Program Eligibility Requirements

a. Overview

CMS finalizes two modifications to the Shared Savings Program eligibility requirements for implementation on January 1, 2024. These policies are discussed in more detail in sections (b) and (c) below:

- Removes the option for ACOs (for agreement periods on or after January 1, 2024) to request an exception to the shared governance requirement that 75 percent control of an ACO's governing body must be held by ACO participants.
- Codifies the existing Shared Savings Program operational approach to specify that CMS determines that an ACO participant TIN participated in a performance-based risk Medicare ACO initiative if it was or will be included on a participant list used in financial reconciliation for a performance year under performance-based risk during the 5 most recent performance years.

b. Shared Governance Requirement

(1) Background

In the November 2011 final rule (76 FR 67819), CMS finalized policies that require an ACO to establish and maintain a governing body with adequate authority to execute the statutory functions of an ACO, which were codified in the governing body policies at §425.106. Specifically, this section mandates that at least 75 percent control of an ACO's governing body must be held by ACO participants. In the December 2014 Medicare Shared Savings Program proposed rule (79 FR 72776), CMS proposed to revise §425.106(c)(5) to remove the flexibility for ACOs to deviate from the requirement that at least 75 percent control of an ACO's governing body must be held by ACO participants. CMS stated that, through program implementation, it learned that ACO applicants do not have difficulty meeting the requirements that ACO participants maintain 75 percent control of the governing body.

During the public comment period for the December 2014 Medicare Shared Savings Program proposed rule, several commenters advocated for retaining the flexibility offered at §425.106(c)(5), stating that an ACO may elect to utilize the exception in the future. CMS states that since implementation of the requirement remained in the early stages and it had limited applicability with ACOs in two-sided risk tracks, it declined to finalize the proposal and elected to retain this flexibility. In the final rule, CMS noted that it anticipated granting such exceptions only in limited circumstances (that is, an ACO being unable to meet the 75 percent participant control requirement because it conflicts with other laws) and might revisit this issue in future rulemaking.

(2) Revisions

CMS continues to believe that ACO participants should drive ACO leadership to move toward improved quality of care and patient outcomes, and that this is a key component of ACO success and ability to earn shared savings. The 75 percent participant control threshold is critical to ensuring that governing bodies are participant-led and best positioned to meet program goals, while allowing for partnership with non-Medicare enrolled entities to provide needed capital and infrastructure for ACO formation and administration. Over the years, a few ACOs have requested an exception to form a governing body with less than 75 percent participant control. CMS discovered, based on comments received from the proposed rule, that it had granted an exception to the 75 percent threshold for 3 ACOs and 2 additional ACOs that had an exception at the start of their agreement but are currently meeting the threshold.

To reduce disruption for the few ACOs who do not currently meet the requirements, CMS is finalizing this policy with the modification that the exception will be permitted only for agreement periods beginning before January 1, 2024. Specifically, CMS finalizing its proposal with modification, to specify that the option under §425.106(c)(5) for ACOs to request an exception to the requirement specified in §425.106(c)(3) that 75 percent control of the ACO's governing body must be held by ACO participants is applicable only to agreement periods beginning before January 1, 2024.

Additionally, CMS is finalizing revisions to §425.204(c)(3)(iii) to limit the option for ACOs to request an exception to the 75 percent control requirement under § 425.106(c)(3), as part of their Shared Savings Program applications, to agreement periods beginning before January 1, 2024. Further, it finalizes a technical change to §425.204(c)(3)(ii), to provide a more complete cross-reference to §425.106(c)(2), for clarity and consistency.

c. Identifying ACOs Experienced with Risk Based on TIN's Prior Participation

(1) Background

Under the December 2018 final rule, CMS defines an ACO as "inexperienced with performance-based risk Medicare ACO initiatives" (and therefore eligible to enter an agreement period under the BASIC track's glide path) if less than 40 percent of its ACO participants has participated in a performance-based risk Medicare ACO initiative in "each" of the 5 most recent performance years prior to its Shared Savings Program agreement start date, and the ACO legal entity has not participated in any performance-based risk Medicare ACO initiative (83 FR 67895). Similarly, an ACO is "experienced with performance-based risk Medicare ACO initiatives" if 40 percent or more of its ACO participants has participated in a performance-based risk Medicare ACO initiative in "any" of the 5 most recent performance years prior to its Shared Savings Program agreement start date (83 FR 67895). In other words, an ACO is inexperienced with performance-based risk Medicare ACO initiatives as long as it does not meet the definition of "experienced with performance-based risk Medicare ACO initiatives" in any of the five most recent performance years prior to the ACO's agreement start date.

CMS recognizes that some ACOs or TINs in performance-based risk Medicare ACO initiatives participate for only part of a performance year, but its current regulation text does not specify the duration of participation required for CMS to determine that an ACO participant TIN has participated in a performance-based risk Medicare ACO initiative.

(2) Revisions

CMS finalizes its proposal to codify the current operational approach for determining whether an ACO participant has participated in a performance-based risk Medicare ACO initiative. Under its current operational approach, an ACO participant is considered to have participated in a performance-based risk Medicare ACO initiative if its TIN was or will be used to calculate financial reconciliation for the entity participating in such ACO initiative ("Initiative ACO"). In general, if an ACO participant was included on an Initiative ACO's participant list for a performance year during the 5 most recent performance years before the ACO's agreement start date, and the Initiative ACO is, or will be, financially reconciled for that performance year, the ACO participant will be considered to have participated in the Initiative ACO.

Accordingly, CMS modifies the existing definitions for "experienced with performance-based risk Medicare ACO initiatives" and "inexperienced with performance-based risk Medicare ACO initiatives" at §425.20 to include the following new sentence at the end of each definition: "An ACO participant is considered to have participated in a performance-based risk Medicare ACO initiative if the ACO participant TIN was or will be included in financial reconciliation for a

performance year under such initiative during any of the 5 most recent performance years." It also makes a technical correction to remove the language "as defined under this section" from both definitions. These amendments are effective on January 1, 2024.

Commenters were generally supportive of the proposal to codify the existing Shared Savings Program operational approach, though some commenters requested further clarification on the methodology. CMS in reply states the defining ACO participants to include all NPIs that have reassigned their billing rights to the TIN is a means to allowing the ACO's redesigned care processes to more broadly reach all Medicare FFS beneficiaries that may receive care from ACO participants.

7. Technical Changes to References in Shared Savings Program Regulations

In this section, CMS makes technical changes to references in the Shared Savings program regulations on ACO's assignment methodology selection, the definition of rural health clinic, the definition of at-risk beneficiary, and terminology in regulations on data sharing with ACOs. These are intended to fix inconsistencies in regulatory references, typographical errors, and make conforming changes.

All commenters supported these proposals and provided no further elaboration or suggestions, stating that these technical changes will eliminate errors and inconsistencies and improve clarity in the regulatory text.

8. Comment Solicitation on Potential Future Developments to Shared Savings Program Policies

a. Background

CMS' vision is to have all beneficiaries in the traditional Medicare program cared for by health care providers who are accountable for costs and quality of care by 2030. It believes that ACOs participating in the Shared Savings Program and Center for Medicare and Medicaid Innovation (CMMI) models are integral in achieving this vision.[27] In the 2023 PFS final rule, CMS adopted several policies to further this goal including: providing advance investment payments to certain new, low-revenue ACOs to build infrastructure; reinstating a sliding scale reflecting an ACO's quality performance for use in determining shared savings for ACOs and shared losses for ENHANCED track ACOs; modifying the benchmarking methodology to strengthen financial incentives for long-term participation; mitigating bias in regional expenditure calculations for ACOs electing prospective assignment; and expanding opportunities for certain low-revenue ACOs participating in the BASIC track to share in savings.

CMS continues to receive significant input from interested parties regarding opportunities to increase participation in ACO initiatives. One such option would be to identify ways that the Shared Savings Program can support ACOs' efforts to strengthen primary care, such as by providing prospective payments for primary care that would reduce reliance on fee-for-service

[27] Jacobs D, Rawal P, Fowler L, Seshamani M. Expanding Accountable Care's Reach among Medicare Beneficiaries. NEJM.org, April 27, 2022, available at https://www.nejm.org/doi/full/10.1056/NEJMp2202991.

payments and support innovations in care delivery. Another option would be to offer a higher risk track in the Shared Savings Program, on which CMS discusses and requests input below.

b. Incorporating a Higher Risk Track than the ENHANCED Track

Over time, CMS has considered a higher risk Shared Savings Program track under which the shared savings/loss rate would be somewhere between 80 percent and 100 percent (that is, a rate higher than that currently offered under the ENHANCED track of 75 percent) that builds on the experience of the Next Generation ACO (NGACO) and ACO Realizing Equity, Access, and Community Health (ACO REACH) Models. This would provide more potential upside for reward in the program and also incentivize ACOs to improve performance in the program, which may result in reduced healthcare costs for Medicare.

In the Shared Savings Program, an ACO can qualify for a shared savings payment if it meets a minimum savings requirement (MSR), meets the quality performance standard or alternative quality performance or alternative quality performance standard, and otherwise maintain its eligibility to participate in the Shared Savings Program. For ACOs meeting the applicable quality performance standard established, the final shared savings rate is equal to the maximum sharing rate specific to the ACO's track/level of participation as follows: 40 percent for ACOs participating in Level A or Level B of the BASIC track, 50 percent for ACOs participating in Levels C, D, or E of the BASIC track, and 75 percent for ACOs participating in the ENHANCED track. Beginning in PY 2023, ACOs meeting the MSR requirement that do not meet the applicable quality performance standard, as applicable, but meet the alternative quality performance standard will have the opportunity to share in savings at a lower rate that is scaled by the ACO's quality performance. Additionally, beginning in PY 2024, certain ACOs participating in the BASIC track that do not meet the MSR have the opportunity to share in savings at a rate that is equal to half of the rate to which they would have otherwise been entitled had they met the MSR.

ACOs that operate under a two-sided model and have losses that meet or exceed a minimum loss rate (MLR) must share losses with the Medicare program. Once this MLR is met or exceeded, the ACO will share in losses at a rate determined according to the ACO's track/level of participation, up to a loss recoupment limit (also referred to as the loss sharing limit). In determining shared losses, ACOs participating in Level C, D, or E of the BASIC track are subject to a fixed shared loss rate (also referred to as the loss sharing rate) of 30 percent. ENHANCED track ACOs are subject to a loss rate that is scaled by the ACO's quality performance, subject to a minimum of 40 percent and a maximum of 75 percent.

In the NGACO Model, NGACOs were offered the choice between two risk arrangements, partial risk or full risk. Under both arrangements, the NGACO was responsible for 100 percent of performance year expenditures, for services rendered to the NGACO's aligned beneficiaries. Under the partial risk arrangement, the NGACO could receive or owe up to 80 percent of savings/losses, whereas under the full risk arrangement, the NGACO could receive or owe up to 100 percent of savings/losses. To mitigate the ACO's risk of large shared losses, as well as to protect the Medicare Trust Funds against paying out excessive shared savings, NGACOs were required to choose a cap on gross savings/losses. The cap, expressed as a percentage of the

benchmark, ranged from 5 percent to 15 percent. The risk arrangement chosen by the NGACO (80 or 100 percent) was applied to gross savings or losses after the application of the cap. In PYs 1-3, a standard discount of 3 percent was applied to the NGACO's benchmark, with various adjustments that allowed the final discount to vary from 0.5 percent to 4.5 percent. In PYs 4-6, a discount of 0.5 percent was applied to the benchmark under the partial risk arrangement, and a discount of 1.25 was applied to the benchmark under the full risk arrangement. The purpose of the discount was to ensure that CMS received a financial benefit from any savings achieved by the NGACOs participating in the model.

Under the ACO REACH Model, REACH ACOs are offered the choice of participating under the Global or the Professional Risk Options. The ACO REACH ACO is responsible for 100 percent of performance year expenditures for services rendered to aligned beneficiaries. Because ACOs electing the Global Risk Option retain up to 100 percent of the savings/losses, a discount is applied to the benchmark to ensure savings are also generated for CMS. Consequently, for ACOs in the Global Risk Option, the benchmark is reduced by a fixed percentage based on the performance year. The benchmark for ACOs participating in the Professional Option does not include this discount, and these ACOs are only eligible to retain 50 percent of savings or owe 50 percent of any losses.

CMS expresses concern that ACOs in a higher risk track could have an increased incentive (relative to existing Shared Savings Program risk models) to avoid high-cost beneficiaries in the performance year in order to maximize their potential shared savings payment or avoid or reduce potential shared losses. If introducing a higher risk-track to the program, CMS states that it would need to consider whether the program's existing approach to expenditure truncation and capping shared savings and shared losses would be sufficient in curbing incentives for ACOs to engage in beneficiary selection in light of the higher potential risk and reward, while ensuring that the new risk model will still be attractive to ACOs and improve the quality and efficiency of the care their assigned beneficiaries receive.

Overall, many commenters supported a higher risk track option in the Shared Savings Program, with many suggesting that this could serve as a track for ACO REACH Model participants to transition into the Shared Savings Program when that model expires at the end of 2026. Commenters offered the following specific suggestions on financial model design elements for a higher risk track.

Shared savings/shared losses rate suggestions: 100 percent shared savings/shared losses rate; choice between a full-risk model with a discount or a shared savings rate of 85 or 90 percent; asymmetrical upside versus downside financial risk options.

Discount to benchmark options: Cap discount at 50 percent of the average shared savings rate; expressed serious concern with the viability of a 3 percent discount for participation; recommended that the discount be no more than 2 percent.

Payment methodology other than Medicare FFS payment suggestions: CMS listed the terms that commenters suggested including "prospective payments for primary care," "prospective

payments," "population-based payments," "team-based care," "advanced payment option," "bundled payments," and "hybrid payment option that includes primary care capitation."

Payments to ACOs or directly to providers and suppliers suggestions: ACOs should have a choice of whether CMS makes prospective payments to the ACO or directly to the primary care practices; clearer guidelines for what portion of a capitated payment an ACO itself may retain, rather than share with its ACO participants.

Ways to protect ACOS serving high-risk beneficiaries and reduce incentives for ACOs to avoid high-risk beneficiaries: Incorporate risk corridors or additional risk adjustment to account for treatment of complex and high-cost beneficiaries; incorporate safeguards and policies in place under the ACO REACH Model to reduce the potential for cherry-picking of beneficiaries.

CMS states that it will consider this information to inform future rulemaking.

c. Increasing the Amount of the Prior Savings Adjustment

Under section 1899(d)(1)(B)(ii) of the Act, an ACO's benchmark must be reset at the start of each agreement period using the most recent available 3 years of expenditures for Parts A and B services for beneficiaries assigned to the ACO. Based on its statutory authority, CMS established a prior savings adjustment that will apply when establishing the benchmark for eligible ACOs entering an agreement period beginning on January 1, 2024, or in subsequent years, to account for the average per capita amount of savings generated during the ACO's prior agreement period. Specifically, in the 2023 PFS final rule (87 FR 69902), CMS finalized a policy to apply a 50 percent scaling factor to the pro-rated positive average per capita prior savings.

ACOs and other interested parties commented that CMS should consider using a higher scaling factor that may more closely match the maximum shared savings rate from an ACO's prior agreement period. CMS, however, believed that the 50 percent scaling factor would be appropriate because it represents a middle ground between the maximum sharing rate of 75 percent under the ENHANCED track and the lower sharing rates available under the BASIC track (e.g., 40 percent). MedPAC commented on the 2023 PFS proposed rule that while the prior savings adjustment is a reasonable policy for mitigating ratcheting effects, implementing both the prior savings adjustment and the regional adjustment policies together would be duplicative. CMS notes, however, that for most ACOs, the positive regional adjustment would exceed the prior savings adjustment, and thus its policy of applying the larger of the regional adjustment and the prior savings adjustment potentially mitigates this concern.

The majority of comments were supportive of increasing the prior savings adjustment in at least one of the ways described in the proposed rule, with several commenters specifically recommending using the maximum shared savings rate the ACO was eligible to receive during the benchmark years. MedPAC was opposed to increasing the amount of prior savings adjustment to align with the higher shared savings rate available under the ENHANCED track and suggested as an alternative that the prior savings adjustment should serve as a mechanism for phasing out the regional adjustment entirely.

Other comments recommended increasing the cap on the prior savings adjustment beyond 5 percent of national per-capita FFS expenditures, implementing a quartile-based benchmark system similar to Medicare Advantage, and calculating the prior savings adjustment at the TIN level instead of the ACO level.

CMS states that it will consider this information to inform future rulemaking.

d. Expanding the ACPT Over Time and Addressing Overall Market-wide Ratchet Effects

In the 2023 PFS final rule, CMS finalized a policy for agreement periods beginning on January 1, 2024, and in subsequent years to incorporate a prospectively projected administrative growth factor, a variant of the United States Per Capita Cost (USPCC) that it refers to 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 performance year in the ACO's agreement period. The three-way blend is calculated as the weighted average of the ACPT (one-third weight) and the existing national-regional "two-way" blend (two-thirds weight). The ACPT will be projected for an ACO's entire agreement period near the start of that agreement period, providing a degree of certainty to ACOs.

The ACPT is intended to insulate a portion of the annual benchmark 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. Because the ACPT is prospectively set at the outset of an agreement period, any savings generated by ACOs during the agreement period would not be reflected in the ACPT component of the three-way blend. Accordingly, incorporation of the ACPT may allow benchmarks to increase beyond actual spending growth rates as ACOs slow spending growth. CMS believed the use of this three-way blend to update ACOs' benchmarks would incentivize greater savings by ACOs and greater program participation.

ACOs and other interested parties expressed concern, however, that the three-way blend effectively increases the proportion of the benchmark update that is based upon national trends, as opposed to regional trends, noting that the blend may not adequately account for geographic variation in spending growth that is outside of an ACO's control. Commenters suggested modifications to the three-way blend to further mitigate potential ratchet effects and to better reflect regional variation in spending. These included modifications such as: (1) keeping a two-way national-regional blend and substituting the national component of the two-way blend with the ACPT; and (2) adjusting the weight of the ACPT in the three-way blend to reflect each ACO's market penetration, as is done with the national component of the two-way blend. CMS declined to implement these suggestions in the 2023 PFS final rule.

Many commenters supported replacing the national component of the two-way blend with the ACPT over use of the three-way blend finalized in the 2023 PFS final rule. Other commenters recommended that CMS remove an ACO's assigned beneficiaries from the assignable population for the region when calculating the update and most of these commenters were also

supportive of substituting the ACPT for the national component of the two-way blend. Several commenters were also concerned about the 5-year projection used in the ACPT and favored projecting the ACPT out for 3 years instead.

CMS states that it will consider this information to inform future rulemaking.

e. Promoting ACO and Community Based Organizations (CBOs) Collaboration

CMS sought comment on ways to improve and incentivize collaboration between ACOs and interested parties in the community or Community Based Organizations (CBOs). It defines CBOs as public or private not-for-profit entities that provide specific services to the community or targeted populations in the community to address the health and social needs of those populations. They may include community-action agencies, housing agencies, area agencies on aging, or other non-profits that apply for grants to perform social services. They may receive grants from other agencies in the Department of Health and Human Services, including federal grants administered by the Administration for Children and Families (ACF), Administration for Community Living (ACL), or the Centers for Disease Control and Prevention, or from state-funded grants to provide social services. CMS states that it recognizes that ACOs wishing to address social needs may want to make investments in goods or social services that would enable their ACO participants and ACO providers/suppliers to work with CBOs that have expertise in identifying and providing the types of social services that the ACO's beneficiary population requires.

CMS notes that the Shared Savings Program does not prohibit ACOs from partnering with CBOs. Currently, if a CBO is enrolled in Medicare, it may already be an ACO participant or an ACO provider/supplier. CMS believes CBOs could play an important role in identifying and addressing gaps in health equity. As CMS stated in the 2023 PFS final rule, it hopes to encourage more ACOs to partner with CBOs whether they provide items and services reimbursed by Medicare or not.

Commenters were generally supportive of increasing collaboration between ACOs and CBOs with some noting that they are actively working with community partners to address SDOH and are working to close the loop between referrals to social services and follow-up interventions. They also encouraged CMS to consider increasing financial support and that more stable and predictable funding mechanism would sustain ACO-CBO collaborations beyond using shared savings to support them. They also shared some potential program risks from advancing these collaborations. In particular, they expressed concern regarding the capacity of CBOs to furnish care as increasing collaboration could strain the CBOs resources and increase the demand of those resources.

Commenters shared further suggestions with CMS (listed below) and stressed the need for CMS to provide non-financial support in increasing ACO-CBO collaborations. These included:

- Providing additional "technical assistance," as well as additional program guidance and resources to ACOs that they can use when establishing or expanding partnerships with CBOs in the community.

- Conduct outreach and provide support to CBOs that may be interested in collaborating with ACOs.
- Expand payment mechanisms using a similar approach embedded in the Maryland Total Cost of Care (TCOC) Model for supporting collaboration with CBOs.
- Add an ACO quality measure to assess the percentage of the ACO population screened for health-related social needs, and the percentage of the population that had an intervention delivered by a CBO.
- Improve SDOH data collection and expand and refine the use of payment methodologies that appropriately address the health, social, and equity goals of the community.

CMS states that it will consider this information to inform future rulemaking.

9. Impact on Medicare Shared Savings Program

The policies in this rule are incremental refinements to the broader changes finalized in the 2023 PFS final rule (87 FR 69777 through 69968). Those changes were designed to reverse recent trends where program participation had plateaued, higher spending populations were increasingly underrepresented in the program since the change to regionally-adjusted benchmarks, and access to ACOs appeared inequitable as evidenced by data indicating underserved populations are less likely to be assigned to a Shared Savings Program ACO, and to encourage growth of ACOs in underserved communities. The changes to Shared Savings Program policies include modifications designed to further these goals in concert with implementation of certain changes finalized in the 2023 PFS final rule, which are applicable for agreement periods beginning on January 1, 2024, and in subsequent years. CMS models the impact of four of its proposals, which are described in the table below.

Combined, the estimated savings from these proposals is expected to result in a $330 million decrease in total program spending over the 10-year period 2024 through 2033.[28] Net savings are expected to be greater toward the end of the 10-year scoring window because residual savings from added ACO participation would grow, whereas benchmarks would not be as impacted in the later part of the scoring window. The combined impact estimates range from expected savings of $2 billion to a cost of $1.7 billion. The large range in the low and high estimates depend on the extent to which additional shared savings payments from higher benchmarks are offset by participation of new high spending ACOs for which savings are generated for the Medicare program.

[28] Tables 123, 124, 125, and 126 in the final rule provide detailed impacts for each of these policies for the 10-year scoring window.

2024 Shared Savings Policy ($ Millions)	Impact Estimate (2024-2033)	Low Estimate (2024-2033)	High Estimate (2024-2033)
Projected Impact of Adjustment Factor to Apply Risk Score Cap to Regional Portion of Blended Update Factor Calculation	**370**	220	540
Projected Combined Impact of Quality Policies to (a) Use Rolling 3-Year Historical Period to Calculate the 40th Percentile of the MIPS Quality Performance Category Scores and (b) Use the 'Higher Of Value' When Measures are Suppressed	**110**	0	320
Projected Impact of Policy to Mitigate the Impact of Negative Regional Adjustment on Benchmarks	**-490**	-1,220	210
Projected Impact of Policy to Use Uniform Approach to Calculate Risk Scores in the Shared Savings Program Benchmark Calculations	**-320**	-1,040	630
Combined Impact of Shared Savings Policies	**-330**	-2,040	1,700

The remaining policy changes to the Shared Savings Program regulations are not estimated to have an impact on program spending at the aggregate level.