2023 PFS Final Rule: 8 Key Strategies that Boost New ACOs and Increase Health Care Access

written by Dave Halpert | November 7, 2022

It's here. The 2023 CMS Physician Fee Schedule Final Rule has been released, and in a mere 3,304 pages, CMS has largely finalized its proposals from over the summer. To save you from pouring through all the minutiae, here's what you need to know.

Overall, in this Final Rule, CMS has codified principles to fulfill the goals outlined in the Innovation Center's Strategic Refresh of October 2021. Most notably, CMS has committed to having all Traditional Medicare beneficiaries in an accountable care program by 2030, and to prioritize health equity.

To make this happen, CMS needs to shake up the status quo. ACO participants have plateaued, and underserved and minority patients are underrepresented. So, here are CMS's eight key strategies to break down barriers for new ACOs, move clinicians out of Traditional MIPS, and provide entities the resources they need to care for patients from all walks of life:

1. Provide Advance Incentive Payments (AIPs) to Accelerate ACO Growth

Among the biggest barriers to entering the ACO market are startup costs. These are particularly problematic for smaller, physician-led groups, and groups in rural markets. To overcome this obstacle, CMS will provide advance shared savings payments to Low Revenue ACOs that do not have experience in two-sided risk models. As a refresher, a Low Revenue ACO is one with combined A and B expenditures that are less than 35 percent of its population's total A and B expenditures. These tend to be physician-led ACOs, rather than hospital-led ACOs, as a hospital or health system will account for more than 35 percent of costs.

These Advance Incentive Payments (AIPs) may be used to staff up, to invest in the technical infrastructure needed to measure and improve patients' health, to provide care for underserved beneficiaries, and to address Social Determinants of Health (SDOH). AIPs will consist of a one-time, upfront payment of $250,000, with two years of quarterly payments to follow. These payments will vary and will be higher for ACOs whose populations reside in a high deprivation area (measured by the Area Deprivation Index) or who are dually eligible. CMS expects these AIPs to increase ACO participation and the number of beneficiaries covered under ACOs, and, specifically, to bring in patients who are underrepresented in the existing ACO beneficiary pool.

2. Allow ACOs to Delay Two-Sided Risk

In a major departure from the "Pathways to Success" Rule, CMS will allow ACOs without performance-based risk experience to take additional time before transitioning to a two-sided model. These ACOs can remain in a one-sided arrangement for the entire five-year agreement, plus the first two years of the next agreement, rather than automatically graduating to risk after two years.

There is also good news for existing ACOs. Those without performance-based risk experience can remain in a one-sided model for the remainder of their agreement. ACOs who do have experience with risk may remain in the final level (Level E) of the BASIC Track in perpetuity, rather than being forced into the ENHANCED Track. Both BASIC Track Level E and the ENHANCED Track qualify as Advanced APMs, but the ENHANCED Track carries more risk.

3. Address the Ratcheting Effect in Existing Benchmarking Methodologies

One of the most frustrating issues for ACOs has been benchmarking. When an ACO performs

well and generates savings, the existing benchmarking methodology raises their bar for the next year—the better they do, the more is expected of them. This "Ratcheting Effect" is felt in the Regional benchmarking and prior-beneficiary spending components of benchmark calculations, continually diminishing an opportunity for savings, and potentially leading to losses.

As an ACO's market penetration increases, CMS will assign less weight to the regional component of the regional-national blend and add more to the national component. The amount that can be negatively adjusted based on region has decreased from 5 to 1.5 percent. This is particularly good news for ACOs who comprise the majority of their respective markets. In earlier years, ACOs with high market penetration would produce savings in their area, only to find their cost benchmark reduced as well. Since spending was reduced in the region, the ACO was expected to spend less, even though the reduced spending was the direct result of that ACO's efforts.

Benchmarks will also account for prior savings, which was a frequently lamented issue in past years. Previously, if an ACO demonstrated success and earned shared savings, their benchmark would be lowered to reflect decreased beneficiary spending. In other words, by performing well in one year, the ACO sabotaged its chances of success in future years. Benchmarks will now have per capita savings added back into their benchmark, which will limit the ratcheting effect on the rebased historical benchmark. Furthermore, CMS finalized its proposal to factor the Accountable Care Prospective Trend (ACPT), a growth factor similar to Per Capita Cost, in its benchmarking methodology. It will be established at the beginning of the ACO's agreement period, and it will be fixed. This will provide consistency and help to mitigate an ACO's impact on its own benchmark.

4. Encourage Quality Reporting on All Patients

The 2024 year will be ACOs' last opportunity to report quality measures through the CMS Web Interface. With this transition looming, CMS has been attempting to entice ACOs to report electronic clinical quality measures (eCQMs) or MIPS Clinical Quality Measures (MIPS CQMs) through the Alternate Payment Model Performance Pathway, or "APP." These measures include all patients (e.g. private health plans, Medicaid, self-pay, etc.), rather than a subset of Medicare patients. Reporting on the entire population promotes equity by adopting a single, high standard of care for all patients. However, these efforts have been largely unsuccessful. As of 2021, only 12 ACOs opted to report eCQMs/CQMs instead of the Web Interface.

There are two primary reasons for this delay. First, for ACOs comprised of different practices on different EHRs, the ACO has not developed a data aggregation solution that enables them to

track a patient from one practice to the next. CMS claims data only includes Medicare patients, and so the remainder of patients are unaccounted for. Aside from the obvious quality gap this will cause with respect to outcomes and costs, it also precludes accurate numerator and denominator calculations, as measures apply at the patient level (not the patient-practice level) and may require the most recent value. Those who cannot track patients across the network cannot report through the APP.

Second, by including all patients, performance may suffer for ACOs with large underserved populations. Social Determinants of Health and income inequality play a significant role in poor outcomes for patients with chronic disease, and so ACOs are likely to see performance rates drop when reporting globally. This is the polar opposite effect that CMS has intended with regards to health equity, and this Rule needed to incentivize ACOs to report through the APP, and to do so before the 2025 requirement.

They have addressed this issue in several ways. In particular, they have eased performance requirements for those reporting eCQMs/CQMs for all patients.

In 2023, if the ACO meets the data completion threshold (70 percent of eligible patients, just like in MIPS), the ACO's quality performance score only needs to equate to the 10th percentile of the performance benchmark for one of the outcome measures, and the 30th percentile for the others. CMS Web Interface reporters are held to a higher standard, needing to achieve a score at or above the 30th percentile in all categories.

In 2024, the ACO will need to achieve the 40th percentile on the other measures, but the outcome measure will still only require performance at the 10th percentile. Those reporting via the Web Interface have their bar raised, as well, needing to achieve a score equivalent to the 40th percentile in all categories. Once eCQMs/CQMs reporting becomes mandatory (beginning in 2025), an ACO must report via the APP and achieve the 40th percentile in all measures to earn the maximum rate of shared savings.

In addition to these eased performance standards in 2023 and 2024, ACOs who report the all-patient measures and who serve a high rate of underserved patients may receive a Health Equity Adjustment consisting of up to 10 points towards their Quality Score. To further sweeten the deal, CMS is instating a sliding scale approach for quality performance. Rather than the previous "all-or-nothing" approach, ACOs will still be able to share some savings, even if their quality performance is lacking.

5. Reduce the Appeal of Traditional MIPS

Even though CMS has offered a bounty of benefits for those who start or continue on the ACO path, many would rather stay the course in Traditional MIPS. After all, scores have been high, and while the bonuses have been underwhelming, penalties have largely been avoided. To get people out of Traditional MIPS, CMS must either sunset the program (which was mentioned, but no timeline was adopted) or make it challenging enough to prompt entities to consider alternate methods of Quality Payment Program participation. In this rule, they have opted for the latter.

Although there are 200 quality measures to choose from in Traditional MIPS, they are not distributed evenly among specialties. As a result, certain specialties (e.g. anesthesiologists, hospitalists) are locked into a relatively small set of measures. When these measures are not benchmarked, or where a quirk in the denominator limits the number of eligible patients, these measures have previously earned 3 points out of a possible 10.

This has hurt scores, but at least 3 points was something, and could be made up in bonus points earned by reporting additional outcome or "high-priority" measures. In 2023, both the 3-point floor and those bonus points are going away, meaning that scores in 2023 can plummet, even if reporting on the same measures used in 2022. With participants again needing to earn an overall MIPS score of 75 to avoid a penalty, the elimination of these points can be profoundly detrimental.

6. Transition to MIPS Value Pathways

CMS continues the MIPS Value Pathway (MVP) rollout, finalizing the five new proposed MVPs along with the previously established seven. Their goal is to eventually replace Traditional MIPS with MVPs; additional MVPs are in development, and groups will be allowed to submit MVP candidates to CMS for approval. This will ensure that all clinicians will have a valid participation option.

For multispecialty groups, CMS has reaffirmed that, by 2026, subgroup reporting will be mandatory, but optional from 2023 through 2025. Subgroups will be defined using Part B Claims data, but during registration, subgroups will have the opportunity to describe their construction (e.g. "this subgroup represents our orthopedics service line, consisting of orthopedic surgeons, sports medicine physicians, physical therapists, and nurse practitioners"). For scoring purposes, a provider (defined by TIN/NPI combination) may only participate in one MVP. Of course, a provider may be involved in care related to another MVP, but that provider would only be scored in the MVP in which they participate.

MVPs are intended to replace traditional MIPS, but no timeline for that has been finalized, and so MVPs will remain optional for the foreseeable future.

7. Increase Focus on Interoperability

All programs under the QPP umbrella are required to report Promoting Interoperability (PI) measures to demonstrate how effectively their EHR facilitates communication between providers, patients, and other entities. Updates to these measures affect everybody, and 2023 brings significant changes that reflect CMS's strategies to improve data security and patient safety, to eliminate "Information Blocking," and to facilitate data sharing between EHRs and Public Health and Clinical Data Registries.

More providers will be required to report on these measures. Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists and Certified Registered Nurse Anesthetists receive automatic PI reweighting in 2022, but beginning in 2023, they must participate.

PI scoring has also been revised, with more weight placed on the Public Health and Clinical Data Exchange objective and less on the Health Information Exchange objective. Furthermore, the definition of "Active Engagement" with respect to the Public Health and Clinical Data Exchange measures has been changed from three options to two. Participants will need to submit whether they are in the Pre-production/Validation stage or have moved to Validated Data Production. Beginning in 2024, clinicians will only be allowed to submit the first option in one performance period, unless they are establishing a connection with another Registry.

8. Request Feedback on How to Incentivize APM Participation

One hitch that CMS has encountered in transitioning people into APMs is that the final 5 percent lump-sum APM payment incentive is being paid in 2024, based on 2022 performance. It will not be available for 2023 APM participants. CMS recognizes that this may act as a disincentive to Advanced APM participation, and they are looking for feedback on how to address this, but there will be no action until 2024. There will be a conversion factor applied to APM Qualified Participants (QPs), but it will not eclipse the incentives that CMS expects MIPS participants to earn.

In the meantime, though, the Generally Applicable Nominal Risk Standard of 8 percent (the total risk shouldered by the APM) will not expire, and in fact, will become permanent. This also applies to Advanced APMs under MIPS, as well as to ACOs. With maximum MIPS penalties set at 9 percent, even the most risk-averse entities should consider APM participation.

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