CMS 2023 Proposed Rule Accelerates ACOs, MVPs

written by Dave Halpert | July 12, 2022

CMS just set off summer fireworks, amping up incentives to adopt Value-Based Care in its just-released, 2,066-page 2023 Proposed Physician Fee Schedule Rule. By encouraging formation of new ACOs, the Proposed Rule establishes a pathway to expand beneficiaries' access to accountable care.

Last year, CMS committed that every Medicare beneficiary will be in an accountable care relationship by 2030, to ensure quality and total cost control. Its October 2021 Innovation Center's Strategic Refresh identified issues with provider adoption of accountable care networks and alternative payment models (APMs). It also identified two objectives: to drive providers into Accountable Care Networks, and to Advance Health Equity. The risk of financial losses and the lack of provider infrastructure, however, caused ACO volume to plateau, stalling beneficiary volume in accountable care.

The CMS 2023 Proposed Rule addresses those obstacles. Here are nine key takeaways, including four major initiatives for advancing ACOs and five developments in MIPS Value

Pathways:

1. Advance Shared Savings (AIPs) Accelerate New ACOs

In an extremely rare move, CMS is allowing up-front advances on shared savings payments for new ACOs. This provides a new ACO the opportunity to invest in its "Day 0" needs, including staffing, strategies for addressing Social Determinants of Health (SDOH), and Healthcare Provider Infrastructure. Healthcare Provider Infrastructure includes partnerships with Clinical Data Registries that have the ability to aggregate disparate sources of data and analyze the results.

The payments are substantial. Under the CMS 2023 Proposed Rule, new ACOs may receive one up-front lump sum payment of $250,000, followed by additional quarterly payments in the ACO's first two agreement years. These quarterly payments will be calculated on a per-beneficiary basis, and will vary by beneficiaries' risk factors (dual eligible status and an Area Deprivation Index, calculated from census data).

2. More Time for ACOs to Adopt Downside Risk

New ACOs will be able to remain in a one-sided track with no downside risk for a longer time. In fact, new ACOs can remain in a one-sided model for the entirety of their five-year agreement period—a significant increase from the two-years allowed under today's BASIC Track. CMS also proposes slowing the glide path for existing ACOs without performance-based risk experience; they could capitalize on this retrospectively. For performance years beginning in 2023, participants in Levels A or B of the BASIC Track can remain at their current levels for the remainder of their agreements.

CMS gives more latitude to ACOs with more experience, as well. For ACO agreements beginning in 2024, ACOs in the BASIC Track could remain in Level E in perpetuity, rather than move to the ENHANCED track, which offers higher rewards but also higher risk. As an added enticement, there is a proposed sliding scale for shared savings and losses, rather than the current all-or-nothing approach. This is key for low-revenue ACOs, which would be able to share savings even if the Minimum Savings Rate was not met. These proposals are a major departure from the previous Pathways to Success Rule.

This CMS shift defers to existing ACO participation patterns. In the 2022 performance year, 41 percent of ACOs are participating in a one-sided model (Level A or B in the BASIC Track). Of the remaining 59 percent, nearly half have advanced to the two-sided levels of the BASIC Track, with the remainder in the ENHANCED Track. The final level of the BASIC Track (Level E) and the ENHANCED Track qualify as Advanced APMs, allowing providers to avoid more arduous MIPS

quality reporting in favor of ACO reporting. Even when given the chance, however, 89 percent elected to stay one-sided in 2021, and 74 percent have chosen to remain one-sided in 2022.

Combined with the loss of the 5 percent lump sum for participating in an APM in 2023 (this benefit has expired), CMS expressed concerns that, rather than moving up, an ACO may choose to drop form the program altogether. While allowing that the two-sided model is the only way to achieve a value-based care environment, CMS addresses concerns about requiring downside risk too quickly by reevaluating how the ACO program can achieve long-term viability.

3. Rewards for ACOs Reporting Quality on all Patients

In prior rule-making, CMS indicated that it will shortly require ACOs to report on all patients (i.e. Traditional Medicare, Medicaid, Private Health Plan, etc.) through the Alternate Payment Model Performance Pathway, or APP. ACOs immediately raised several issues, one of which was that reporting on patients on Medicaid would be detrimental to their quality performance. Through the CMS Web Interface, ACOs only submit a sample of Traditional Medicare patients. ACOs fear that incorporating a population with historically high levels of chronic illness would put the ACO's shared savings at risk.

To alleviate these concerns while still promoting Health Equity and accountable care arrangements for beneficiaries, in the 2023 PFS Proposed Rule, CMS introduces incentives for early adoption of all-payer reporting, in advance of the closure of the CMS Web Interface. For ACOs with a greater proportion of patients with Medicaid or historically poor access to health care, CMS has proposed awarding bonus points to those ACOs who report at the all-payer level through the APP. The intent is to promote a single, high standard of care for all patients, and to prevent ACOs from receiving poor performance scores when reporting quality measures on the very population that CMS is targeting for Health Equity. It is noteworthy that, in 2021, only 12 ACOs reported eCQMs/MIPS CQMs, using the CMS Web Interface instead.

4. CMS 2023 Proposed Rule Improves ACO Costs Benchmarking

CMS creates ACO benchmarks based on estimated appropriate expenditures. However, the calculation method can negatively impact ACOs that perform well. As successful ACOs' expenditures decrease, these lower costs are figured into CMS's algorithm for calculating future benchmarks. An ACO can sabotage itself in the future by performing well in the beginning, but potentially pivoting from savings to losses over time.

Regional expenditures are also used to calculate ACO benchmarks. In cases where an ACO cares for a majority of the regional population, an ACO's reduced costs will reduce the overall regional expenditures, magnifying the impact on an ACO and potentially curtailing savings.

To mitigate these benchmark pitfalls, CMS has proposed to incorporate an administrative growth factor called the Accountable Care Prospective Trend (ACPT) into the ACO benchmark formula. The ACPT, in combination with both regional and national spending trends, would correct for false-negative results that occur when an ACO's lower costs lead to unachievable benchmarks. Also the benchmark would remain the same throughout an ACO's entire five-year agreement period to create stability and predictability for the ACO.

5. Focus on MIPS Value Pathways but No Official Phase-Out of Traditional MIPS

CMS has stated that "Traditional MIPS," the standard level of MIPS participation, has been confusing for providers, offering too many options for participation. In addition, an anticipated dove-tailing of the Quality, Cost, Improvement Activity, and Promoting Interoperability components has not occurred. In the 2022 Final Rule, CMS floated a potential phase-out of Traditional MIPS in several years. That phase-out is not included in the proposed rule, but the focus is very targeted on MIPS Value Pathways (MVPs) and ACOs rather than Traditional MIPS.

For the immediate future, providers may continue to fulfill Quality Payment Program requirements through the Traditional MIPS track. Compared to the development and guidance accorded to the MVP and APM tracks, however, Traditional MIPS updates are on a maintenance scale. Providers should prepare to make a move to another method of QPP participation.

6. More Financial Drawbacks Under "Traditional MIPS" in Proposed Rule

The minimum threshold (the lowest score before incurring a penalty) is dictated by the mean score in a prior year. CMS has proposed using the same period that they used for 2022 (the 2017 performance period/2019 payment year) for the 2023 benchmark—once again at 75 points.

Unfortunately, the second performance threshold for Exceptional Performance is no longer applicable, as the Tier and its corresponding incentive payment has expired. This is a double whammy for Traditional MIPS participants. Not only is the opportunity for earning additional incentives lost, but also it will be more challenging to avoid penalties in Traditional MIPS in 2023 than in 2022.

In the Quality category, many providers have been able to submit extra Outcome measures, High-Priority measures, or measures without any manual intervention ("end-to-end") to earn extra points. These opportunities to earn bonus points all expire in 2023. For specialties with limited measure availability (or limited availability of measures with benchmarks that are not topped out), the loss of these extra points has the potential to drop a quality score by 10 percent, even when year-over-year performance is the same.

Beyond that disadvantage, in the CMS 2023 Proposed Rule, the agency suggests removing the 3-point floor protecting providers from low-volume or low-performance measures. The floor ensured that providers could gain a score of 3 points out of 10 on any measure, as long as at least 70 percent of the denominator was reported, even if there was no existing benchmark, there were fewer than 20 cases, or if performance was lower than the 3rd performance decile. Removal of the 3-point floor in 2023 means that measures without benchmarks (excluding new measures) or with fewer than 20 cases will have zero points in 2023 for practices with more than 15 providers, and measures at the low end of the performance scale will earn one point.

The 1-10 performance scale may seem appropriate, but consider this: In the 2022 MIPS Historical Quality Benchmarks, a measure for a Plan of Care for Patients at Risk for Falls has an average performance rate of 92.3 percent. But, anything below 94.3 percent falls below the 3rd performance decile. By performing at the average level, a provider would only earn 3 out of 10 points in 2022, and only 1 or 2 points in 2023.

There are also some shake-ups in Promoting Interoperability (PI). First, CMS will no longer automatically reweight NPs, PAs, CRNAs, and CNSs for Promoting Interoperability. CMS also proposes to require the Querying of the Prescription Drug Monitoring Program (PDMP) measure in 2023, rather than one that earned bonus points previously. Finally, Public Health and Clinical Data Exchange requirements are heavier, requiring clinicians to attest to their level of "Active Engagement" with the clinical data entity in question.

7. Reaffirmation of MVPs with 5 New and 7 Updates

In the 2022 Final Rule, CMS defined its MVP policies and outlined an initial list of seven. In this rule, they've made updates to that initial list, which are primarily updates to available Quality Measures and Improvement Activities associated with the MVP. For 2023, the full MVP list is as follows:

Advancing Care for Heart Disease
Optimizing Chronic Disease Management
Advancing Rheumatology Patient Care

Improving Care for Lower Extremity Joint Repair
Adopting Best Practices and Promoting Patient Safety Within Emergency Medicine
Patient Safety and Support of Positive Experiences with Anesthesia
Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
Advancing Cancer Care (New)
Optimal Care for Kidney Health (New)
Optimal Care for Patients with Episodic Neurological Conditions (New)
Supportive Care for Neurodegenerative Conditions (New)
Promoting Wellness (New)

8. Retention of Subgroup Reporting for MVP Participants in Multispecialty Groups

The CMS 2023 Proposed Rule makes no changes to subgroup reporting, nor does it alter the requirement that, by 2026, subgroup reporting will be mandatory for MVPs. Until then, CMS still encourages subgroup reporting, To determine whether a group constitutes a multispecialty group, CMS will use Part B claims data, rather than PECOS (the option originally proposed).

CMS defines several of the "real world" processes of MVP reporting in the proposed rule. First, a subgroup must register with CMS between April 1 and November 30 of the year. The exception to this timeline is if the specified MVP includes a CAHPS survey. In those cases, registration must be completed by June 30 to be consistent with the CAHPS survey registration deadline. Clinicians should note that they may only participate in one MVP per TIN. If a multispecialty group has one subgroup participating in the Promoting Wellness MVP and another in Optimizing Chronic Condition Management MVP, a primary care provider in the TIN would need to choose to participate in one or the other, even though they are both relevant.

The Proposed Rule addresses open issues, such as how subgroup reporting would work for Promoting Interoperability, and will calculate those pieces at the affiliated group level. So, even though a provider may only participate in one subgroup per TIN, that provider may indirectly contribute to the score of another.

The Proposed Rule attempts to assuage concerns of early MVP adopters by specifying that those who register for subgroup MVP reporting, but do not actually submit data, will be held harmless. CMS does not want to discourage those from getting on board early and anticipates some subgroups to abort an early attempt at MVP participation. In addition, CMS will still take the best score for the provider, even if the subgroup's MVP performance is less than the full group. In other words, registering for reporting an MVP at the subgroup level does not lock a clinician into that subgroup's MVP score.

9. CMS Requests for Feedback via RFIs

CMS has embedded several Requests for Information (RFIs) in the CMS 2023 Proposed Rule. These include:

> What should CMS do to mitigate the transition from a lump sum 5 percent APM incentive payment?
> How should CMS develop and implement health equity measures?
> Can measures can be implemented to address amputation avoidance in diabetic patients?
> Should Third Party Intermediaries (like Qualified Registries, QCDRs) have the flexibility to support only certain measures within an MVP?
> Should CME Organizations be able to submit Improvement Activity data directly to CMS?
> How can CMS incentivize participation in the Trusted Exchange Framework and Common Agreement (TEFCA)?
> How should Digital Quality Measures be standardized and implemented through FHIR?
> Would changing Qualified Participant (QP) status to an individual determination encourage specialist providers to further engage in APM performance measurement?

Like other Proposed Rules, there is a 60-day comment period on this rule, which may be accessed at https://www.regulations.gov/. Follow the “Submit a comment” instructions and refer to the file code CMS-1770-P. The comment period closes on September 6, 2022, so get your comments in before then!

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