ROJI INTEL

The 2025 CMS PFS Final Rule:
The Five-Pronged Strategy Toward Comprehensive Accountable Care

By 2030, CMS intends to have all Traditional Medicare patients in a relationship with a clinician who is accountable for total cost of care. This rule will help to bring that goal to fruition. Understanding these five key concepts can determine whether your value-based care journey brings payments or penalties.

1. Rewarding High-Performing ACOs with Prepaid Shared Savings

- ACOs in two-sided models with a track record of earning shared savings may receive an advance on potential shared savings and reinvest them in the ACO and its patients.
- At least half of these savings must go to direct, non-covered beneficiary services; the rest may be spent on health care infrastructure, including Clinical Data Registries that can help you measure and improve performance.
- This is part of a larger CMS strategy to prioritize primary care through up-front investment.

2. Incentives for ACOs in Rural and Underserved Communities

- A Health Equity Benchmark Adjustment (HEBA) will protect ACOs that practice in rural and underserved communities.
- It is calculated based on the proportion of beneficiaries enrolled in the Medicare Part D Low Income Subsidy (LIS) or who are dually eligible for Medicaid and Medicare.
- The HEBA will be a new method for increasing an ACO's historical benchmark, protecting against shared losses and offsetting high startup costs.

3. Termination Protections for Small ACOs

- CMS has had historical difficulties calculating Minimum Loss Rate (MSR) and Minimum Savings Rate (MSR) for ACOs with low beneficiary counts.
- Improved calculations using attributed beneficiary volume and a sliding scale approach has created a guardrail against overpayments and underpayments.
- ACOs with fewer than 5,000 attributed beneficiaries will no longer face automatic termination.

4. Another ACO Quality Reporting Shakeup

- CMS has created the APP Plus Measure Set in order to align ACO quality reporting with the Universal Foundation of Measures.
- APP Plus Measures may be reported as Medicare CQMs, eCQMs, and MIPS CQMs.
- The APP Plus will begin by requiring reporting on four measures, with new measures added each year.

5. MVPs: The Ulterior Motive Behind Favorable MIPS Policies

- Stable MIPS policies are intended to ease a transition to MIPS Value Pathways (MVPs) and Advanced Alternate Payment Models (APMs), including ACOs.
- The MIPS Minimum Performance Threshold remains at 75 points.
- The Quality Measure Data Completion Threshold remains at 75 percent.
- Scoring methodology for MIPS Cost has been updated, so providers who score in the middle of the pack are not disproportionately penalized.

For a more detailed discussion of the 2025 CMS PFS Final Rule, please see our analysis here.

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