Policy Brief
February 2023

UPDATE FOR STATE MEDICAID OFFICIALS

Medicare Shared Savings Program

Under the recently updated Medicare Shared Savings Program (MSSP) rules, the Centers for Medicare & Medicaid Services (CMS) encourages formation of new accountable care organizations (ACOs), particularly to serve rural and underserved beneficiaries. State Medicaid agency staff may be interested in these changes, particularly if state safety net providers choose to form ACOs under the updated rules, or if ACO participation increases as CMS encourages greater movement from traditional fee-for-service to accountable care. Medicaid agencies may also wish to share learnings or align efforts (e.g., related to investments in new ACOs, reducing disparities for underserved populations, ensuring reliable cost savings across years of accountable care arrangements).

This brief provides background about the MSSP and examines key updates from the recently finalized rule. It concludes with considerations and opportunities for states, ranging from adapting the MSSP model for use in Medicaid ACOs, to aligning initiatives or quality measures for greater impact.

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BACKGROUND

Medicare Shared Savings Program History

The MSSP is an ACO model created by the Affordable Care Act and launched in 2012.[1] ACOs are formed by groups of providers agreeing to be held accountable for both the total Medicare Part A and Part B costs of care and the quality of care delivered to assigned beneficiaries, including costs when a beneficiary seeks care outside the ACO.[1] Organizationally, ACOs may be led by physician groups (e.g., federally qualified health centers; FQHCs), hospitals, or a combination.[2]

> "Ensuring high-quality, accountable care for all traditional Medicare beneficiaries by 2030 will require strategic alignment among CMS's ACO efforts. [CMS is] considering several changes to the Shared Savings Program and new models to expand participation in ACOs, increase savings for participants and for Medicare, and make access to ACOs more equitable."[3(pp101)]

The MSSP is now the nation's largest value-based payment program.[4(pp69777)] In addition, the Centers for Medicare & Medicaid Services (CMS) is using the program as a "chassis" to develop and test new ACO models; approaches tested by the Center for Medicare and Medicaid Innovation (CMMI) can then be incorporated into the MSSP and spread nationally.[3] CMMI intends to design models with opportunities for multipayer alignment, and to launch new or modified models with a greater focus on Medicaid.[5] CMS has set goals that by 2030, all traditional Medicare beneficiaries and the vast majority of Medicaid beneficiaries will receive care from providers accountable for both costs and quality.[3,5]

In a recently finalized rule, CMS made substantial changes to the MSSP, intended to improve health equity, reward ACOs which provide quality care to dually eligible and other underserved populations, and increase the number of Medicare beneficiaries in accountable care.[4]

MSSP ACO Overview

Participation in the MSSP is voluntary.[4(pp69816)] To participate, an ACO must have at least 5,000 assigned Medicare fee-for-service (FFS) beneficiaries each year over a 5-year agreement period.[6] The ACO then contracts with participants (e.g., physicians, hospitals [including critical access hospitals], FQHCs, and rural health centers).[7,8(Section 425.116)] The ACO must maintain accurate lists of their participants and must submit the lists to CMS at least annually.[8(Section 425.118(a))] The ACO participants are paid based on the traditional Medicare FFS model; if the ACO meets cost and quality standards, the ACO also may receive shared savings and, in 2-sided risk tracks, ACOs might be subject to downside losses.[4(pp69777, 69830)] At the end of each year, CMS reconciles the billed claims for the ACO's assigned beneficiaries with the ACO's cost benchmark to calculate the shared savings or shared risk pool.[1] The program falls into category 3 on the Health Care Payment Learning & Action Network (HCP-LAN) framework, which is set out in Appendix A.[9]

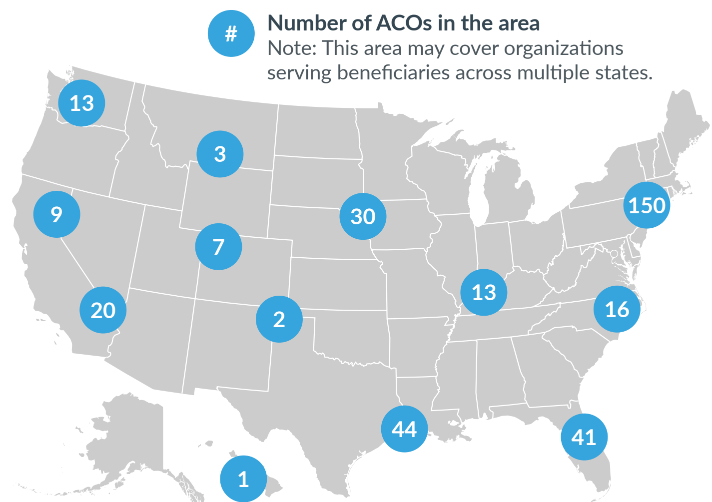
Beneficiaries are assigned to an MSSP ACO if their primary care services were most commonly provided by the ACO's participating providers.[1] Under the prospective assignment option, assignments are fixed at the beginning of the year based on the previous year's services; in retrospective assignment, assignments are made provisionally at the beginning of the year and then finalized at the end of the year.[1] Medicare beneficiaries who are assigned to an ACO still have the option to receive care outside of the ACO.[1]

As of January 2023, MSSP ACOs operate across the country, as depicted in the map in Figure 2.

FIGURE 2

Map of MSSP accountable care organizations

456 Medicare Shared Saving Program ACOs are providing care to 10.9 million beneficiaries.



Source. Centers for Medicare & Medicaid Services.[10]
Abbreviation. ACO: accountable care organization.

For more granular detail, a view of the distribution of Medicare beneficiaries by county is available on the CMS website.[7] Of the Medicare beneficiaries assigned to MSSP ACOs at the beginning of 2023, 6% were aged and dually eligible for Medicaid.[7]

The Medicare beneficiaries who may be assigned to MSSP ACOs do not include those enrolled in Medicare Advantage plans, as they receive their benefits from private plans.[11] Medicare Advantage plan types include dual-eligible special needs plans, which are limited to dual-eligible beneficiaries.[12] The Medicare Payment Advisory Commission projects that enrollment in Medicare Advantage may soon grow to half of all eligible Medicare beneficiaries.[13]

RECENT MSSP CHANGES

Changes to the MSSP will be implemented over several years, as summarized in this timeline (Figure 3) and described in further detail below.

Health Equity Strategies

The MSSP uses several new approaches to increase health equity. To address inequitable trends in which White Medicare beneficiaries are more likely to be assigned to MSSP ACOs than beneficiaries in other racial and ethnic groups,

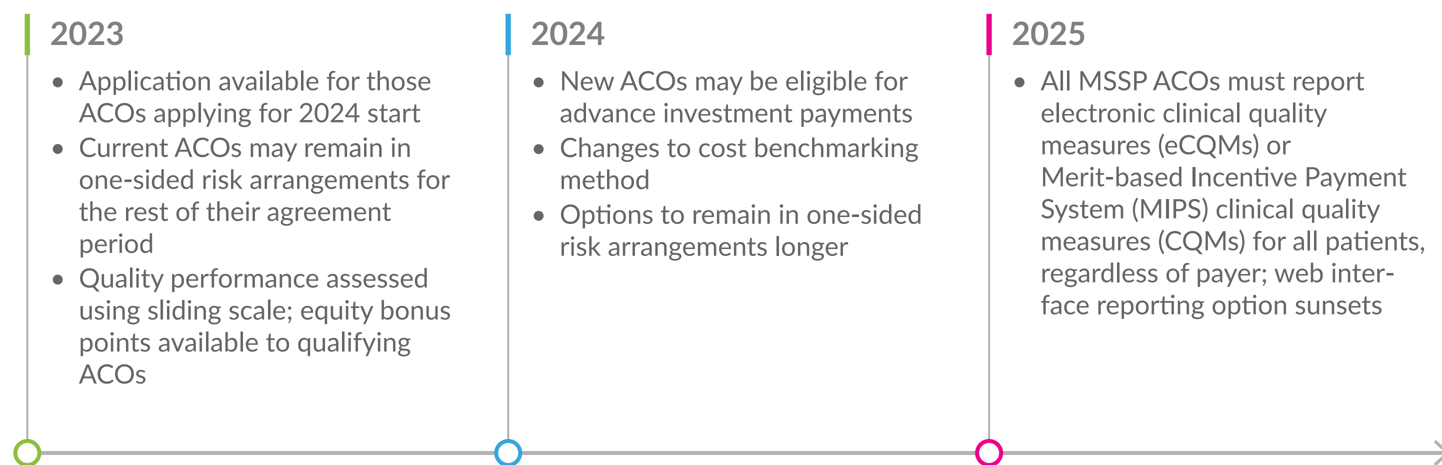
> CMS has equity initiatives underway beyond the MSSP. Another recent rule aims to improve health equity and maternity care by adding new quality measures to hospital quality programs and creating a new designation for "birthing-friendly" hospitals that participate in perinatal quality improvement collaboratives and implement recommended quality interventions.[14] CMS is also testing new approaches to improve health equity in the Realizing Equity, Access, and Community Health (ACO REACH) model, which was redesigned from the Global and Professional Direct Contracting Model; new features that demonstrate success might be added to the MSSP.[3]

CMS has adopted changes to encourage new ACOs to participate.[15] CMS expects that advance investment payments and options for one-sided risk participation will encourage formation of new ACOs serving underserved populations.[15]

In addition, CMS is introducing health equity bonus point adjustments to quality scores for MSSP ACOs that report electronic clinical quality mea-

FIGURE 3

Timeline of MSSP updates



Abbreviations. ACO: accountable care organizations; MSSP: Medicare Shared Savings Program.

sures (eCQMs) or Merit-based Incentive Program clinical quality measures (MIPS CQMs).[15] This health equity adjustment adds bonus points to the quality scores of ACOs that provide high-quality care while caring for a higher proportion of beneficiaries who are underserved or dually eligible.[15]

Advance Investment Payments

For ACOs that start in 2024 or later, a new opportunity will be available for financing start-up costs and addressing the social needs of Medicare beneficiaries. Eligible ACOs may seek upfront payments as they begin participating in the MSSP.[15] These advance investment payments (AIPs) are intended to remove barriers to entry, particularly for ACOs serving rural and underserved populations.[4(pp69784-85)] CMS estimates that, on average, a qualifying ACO could receive AIPs of about $2.5 million.[4(pp69797)]

The first MSSP ACOs eligible to receive AIPs will apply in 2023 to begin new agreement periods in 2024.[4(p69788)] To be eligible for AIPs, an ACO must[8(Sections 425.630(b), 425.20)]:

- Be new to the MSSP (i.e., not renewing or re-entering participation in the program);
- Apply and be eligible to participate in any level of the MSSP basic participation track (discussed below);
- Be inexperienced, based on the combined history of the ACO as a legal entity and the ACO's participants in performance-based Medicare ACO initiatives; and
- Be low-revenue.

Typically, low-revenue ACOs are physician groups, and high-revenue ACOs include hospitals.[4(pp69817, 69808)]

The AIPs have 2 parts: (a) 1 payment of $250,000 to support upfront investments, and (b) 8 quarterly payments, made over 2 years, to provide cash flow.[4(pp69792)] CMS will make the upfront fixed payment and the first quarterly payment at the beginning of the agreement period.[4(pp69797)] Although the payments come during the first 2 years, ACOs have the entire 5-year agreement period to spend the payments.[4(pp69801)]

Quarterly payments are based on risk factor scoring of the ACO's assigned Medicare FFS beneficiaries, for up to 10,000 beneficiaries.[4(pp69800)] The amount of the payment depends on sliding scale scores for beneficiaries' social risk factors[4(pp69800)]:

- Enrollment in the Medicare Part D low-income subsidy;
- Dual eligibility for Medicare and Medicaid; and
- Residence in location with a high area deprivation index (ADI) score.

ACOs must use the AIPs to increase staffing, improve health care infrastructure, and address social determinants of health.[15] The rule provides numerous examples of acceptable uses, which can be found in Appendix C.[4] To provide transparency, ACOs must post to their websites how much they receive and how they spend the AIPs.[15]

These payments are intended to be repaid over time; CMS will recoup AIPs from future shared savings during the agreement period and, if a balance remains, the following agreement period.[15] If no shared savings occur, however, CMS will forgive repayment, unless the ACO leaves the program early (before the end of the agreement period in which it received the AIP).[15]

Participation Tracks and One-sided Risk

Depending on an ACO's experience, the MSSP offers 2 tracks, which start with one-sided risk at the beginning of the basic track and advance to two-sided risk and greater potential rewards.[4(pp69777)] CMS seeks to balance competing considerations of encouraging participation by flexibility in the choice of risk levels and, on the other hand, maximizing two-sided risk to incentivize high-value care.[4(pp69808)] As of January 2023, 151 MSSP ACOs assumed one-sided risk, and another 305 assumed two-sided risk.[7]

Under the recently finalized rule, ACOs may stay in a one-sided risk level for a longer period.[15] Previous CMS rules required ACOs to advance

from one-sided to two-sided risk after 2 or 3 years, with some flexibilities added during the COVID-19 public health emergency.[4(pp69806-07)] In response to concerns that ACOs, particularly smaller providers in rural and underserved areas, need more time to prepare for downside risk, the program will allow inexperienced ACOs to remain in a one-sided risk level (levels A and B in Table 1) for up to 7 years, with the first 5-year agreement period in level A.[15] Experienced ACOs gain flexibility starting in 2024 to choose between the enhanced track or the highest level of the basic track.[15] As noted above, inexperience depends on the combined history of the ACO as a legal entity and its ACO participants; an ACO is inexperienced if neither the ACO itself nor at least 40% of its participants previously participated in performance-based Medicare ACO initiatives or deferred entry into a second MSSP agreement period under a two-sided risk model.[8(Section 425.20)]

For 2023, CMS summarized the potential reward and risk under each option (Table 1).

Quality Measures and Equity Bonus Points

To be eligible for shared savings, MSSP ACOs must meet quality requirements.[8(Section 425.512(a)(1))] Starting in 2023, CMS is replacing the previous, all-or-nothing approach to quality scoring with a

TABLE 1
MSSP Participation Tracks and Risk or Reward for 2023

	Shared Savings (once minimum savings rate met or exceeded)	Shared Losses (once minimum loss rate met or exceeded)
Basic Track's Glide Path		
Levels A and B (one-sided model)	First dollar savings at a rate of 40% if quality performance standard is met; not to exceed 10% of updated benchmark	Not applicable
Level C (risk/reward)	First dollar savings at a rate of 50% if quality performance standard is met; not to exceed 10% of updated benchmark	First dollar losses at a rate of 30%, not to exceed 2% of ACO participant revenue capped at 1% of updated benchmark
Level D (risk/reward)	First dollar savings at a rate of 50% if quality performance standard is met; not to exceed 10% of updated benchmark	First dollar losses at a rate of 30%, not to exceed 4% of ACO participant revenue capped at 1% of updated benchmark
Level E (risk/reward)	First dollar savings at a rate of 50% if quality performance standard is met; not to exceed 10% of updated benchmark	First dollar losses at a rate of 30%, not to exceed 8% of ACO participant revenue in 2019-2024, capped at 4% of updated benchmark. The loss recoupment limit is the percentage of revenue specified in the revenue-based nominal amount standard under the Quality Payment Program, capped at 1 percentage point higher than the benchmark-based nominal risk amount.
Enhanced Track (risk/reward)	First dollar savings at a rate of 75% if quality performance standard is met; not to exceed 20% of updated benchmark	First dollar losses at a rate based on quality performance, with minimum shared loss rate of 40% and maximum of 75%, not to exceed 15% of updated benchmark

Source: Adapted from the Centers for Medicare & Medicaid Services.[16] Abbreviation. ACO: accountable care organization.

sliding scale; if an ACO misses the threshold for maximum shared savings but reaches a minimum standard, the ACO may qualify for a lower rate of shared savings.[15]

Currently, the quality measures for MSSP ACOs include a patient experience survey and 2 administrative claims measures, plus measures reported by the ACO using 1 of these options:

- The CMS Web Interface, through which an ACO reports 10 measures for a CMS-identified sample of the ACO's assigned beneficiaries,[17] or
- eCQMs or MIPS CQMs, for which an ACO reports 3 measures on all-payer basis, meaning that all patients seen by the ACO's participating providers are included.[18]

The CMS Web Interface reporting option will sunset after 2024, and all MSSP ACOs will need to report eCQMs or MIPS CQMs in 2025 and subsequent years.[8(Section 425.512(a)(2))] To encourage an early transition to reporting eCQMs or MIPS CQMs, ACOs that use this data collection method report fewer measures and have lower benchmarks to meet.[4(pp69838),16]

In addition, starting in 2023, ACOs reporting the 3 eCQMs or MIPS CQMs may receive up to 10 health equity adjustment bonus points to be added to their quality scores.[4(pp69856)] These bonus points are intended to reward ACOs that provide high-quality care to underserved populations.[15] CMS anticipates that bonus points will allow ACOs that provide high-quality care to underserved beneficiaries to qualify for relatively higher

TABLE 2
MSSP Quality Measures: Reporting Options and Scoring for Maximum Savings Rate

Measures		Scoring years 2023	2024	2025 and beyond
Quality measures for MSSP ACOs are: • CAHPS for MIPS survey, • 2 administrative claims measures calculated by CMS, and • ***Either*** the 3 eCQMs or MIPS CQMs ***or*** the 10 Web Interface measures.	3 eCQMs or MIPS CQMs • Data completeness and case minimum requirements • Includes all patients, regardless of payer	ACO must achieve a score of: • At least the 10th percentile of the benchmark on an outcome measure, and • At least the 30th percentile of the benchmark on 1 of the other 5 measures in the set	ACO must achieve a score of: • At least the 10th percentile of the benchmark on an outcome measure, and • At least the 40th percentile of the benchmark on 1 of the other 5 measures in the set	ACO must achieve an equity-adjusted score of at least the 40th percentile across all MIPS quality performance category scores
	10 CMS Web Interface measures	ACO must achieve an equity-adjusted score of at least the 30th percentile across all MIPS quality performance category scores	ACO must achieve an equity-adjusted score of at least the 40th percentile across all MIPS quality performance category scores	*Web Interface option sunsets*

Source: Summarized from the Centers for Medicare & Medicaid Services[4(pp69858)]
Abbreviations. CAHPS: Consumer Assessment of Healthcare Providers and Systems; CQM: clinical quality measure; eCQM: electronic clinical quality measure; MIPS: Merit-based Incentive Payment System; MSSP: Medicare Shared Savings Program.

shared savings or lower shared losses.[4(pp69842)]

Equity bonus points are available if at least 20% of the ACO's assigned beneficiaries are underserved, meaning the beneficiaries reside in a location with a high ADI score (the same index used in the AIP calculation), or are enrolled in the Medicare Part D low-income subsidy or dually eligible for Medicare and Medicaid.[4(pp69856)] See Appendix B for information on ADI by state. The bonus points are the product of (a) a scaled score comparing the ACO's quality performance to that of other ACOs and (b) the proportion of underserved beneficiaries among the ACO's total assigned beneficiaries.[4(pp69856)] More details about the calculation can be found in Appendix F.

Benchmarking for Cost Savings or Losses

To encourage continuing participation and cost savings, CMS has updated its approach to cost benchmarking.[15] CMS calculates shared savings or shared losses by comparing an ACO's actual spending with a benchmark spending target.[13] To qualify for shared savings, the ACO also must meet a minimum savings rate requirement, intended to ensure that savings result from the ACO's performance rather than normal fluctuations in annual expenditures.[4(pp69947)] The current benchmark calculation, however, can create a "ratchet" effect that disincentivizes cost reductions: If the benchmark is based on the ACO's previous performance, the ACO has an incentive to avoid sharp reductions in spending, because such reductions will ratchet down the ACO's future benchmarks and make it harder for the ACO to qualify for future shared savings.[13]

To address that concern, starting in 2024, benchmark updates will incorporate an external factor, the accountable care prospective trend, which is based on Medicare FFS growth trends projected by CMS actuaries.[15] In addition to the new accountable care prospective trend factor, benchmark updates will reflect national and regional growth factors.[15] Details of the new methodology are laid out in 42 CFR §425.650 through §425.660.[8] CMS will monitor the effects of this new benchmark methodology and may make refinements in future rulemaking.[15] Also starting in 2024, some low-revenue ACOs that fall short of the minimum savings rate requirement may qualify for shared savings at a reduced rate.[15]

STATE CONSIDERATIONS AND OPPORTUNITIES

Multiple aspects of the MSSP may be of interest to state Medicaid officials. Enrollment may increase, after plateauing in recent years, and recent changes may bring new participants into the MSSP. With the new enhancements to the program—particularly the advance investment payments, benchmarking changes, equity bonus points, and options to extend one-sided risk—safety net providers may show new interest in participation. Growth in MSSP participation may also build competencies in provider networks that help state Medicaid agencies achieve their goals for value-based payments. As CMS has articulated a goal of moving beneficiaries to accountable care arrangements by 2030, the pace of change may increase.

Depending on their state's current delivery models, Medicaid agencies may find a range of opportunities related to the MSSP. However, because MSSP ACOs serve Medicare fee-for-service beneficiaries, states where Medicare Advantage predominates could see less growth in MSSP participation. The spectrum of opportunities is broad, from state Medicaid adoption of the MSSP model, adaption of particular components of the MSSP (e.g., the cost benchmarking calculation or the equity bonus points) for Medicaid use, alignment of Medicaid initiatives and ACO investments for collective impact, and exploration of quality measure alignment. Because of the complexity of providing care and sharing the costs for coverage of the dually eligible population, the opportunities for alignment may be greater among the general Medicaid population, where state programs have

greater flexibility. At the very least, an awareness of the MSSP should be useful for answering questions from care providers about alignment between Medicare and Medicaid.

The following diagram summarizes the range of options discussed below.

FIGURE 4

Summary of MSSP alignment opportunities

- Use MSSP model in program development
- Leverage benchmark approach to calculate savings or loss
- Adapt equity bonus points strategy
- Explore opportunities to leverage ACO quality measures
- Create collective impact with ACO AIP-funded work

Use MSSP Model in Program Development

For state Medicaid agencies exploring ACO implementation, the MSSP model may serve as a framework. Using an MSSP framework could speed program development and implementation among ACOs and participating providers who are already familiar with the MSSP model. These benefits would be particularly significant in states where MSSP ACO-participating providers also care for a substantial portion of the state's Medicaid population. Alignment with Medicare could allow ACOs to achieve greater impact through economics of scale (e.g., by bringing more participating providers into the ACO, or investing in provider infrastructure such as health information technology and analytics platforms).

Among state Medicaid agencies which have already implemented an ACO model, new opportunities may arise to align components with the MSSP. For state Medicaid officials interested in common approaches, CMS's use of the MSSP as the "chassis" to test new Medicare models means fewer variables to track when considering opportunities for alignment with Medicaid. Policies used across multiple models may become more appealing as a standard and commonly understood approach. As participation in the MSSP grows, state officials could explore further opportunities to leverage components of the program. Aligned approaches may allow Medicaid agencies to advance their own payment reform efforts more quickly by using the CMS-developed model, which is already familiar to the provider community.

Leverage Benchmark Approach to Calculate Savings or Loss

With the recent updates to the MSSP, Medicaid programs could explore which components would be most beneficial for alignment. For example, in some states, Medicaid actuaries and others interested in the operations of cost benchmarks may consider alignment with the MSSP's updated approach to mitigate the "rachet" effect of shared savings calculations and incorporate an external, prospective trend factor that accounts for national and regional growth factors.

Adapt Equity Bonus Points Strategy

State Medicaid agencies could adapt the MSSP's model and award bonus points on their quality measures to providers who serve high numbers of underserved beneficiaries. Although Medicaid programs could not simply copy the MSSP approach due to differences in the population served, state Medicaid agencies could assess whether bonus points based on area deprivation or other criteria could identify underserved Medicaid enrollees. State programs seeking methods to incentivize equity might analyze performance and enrollment data and explore an approach of adding bonus points for meeting quality targets while providing care to a substantial share of members who have experienced disparate outcomes.

Explore Opportunities to Leverage ACO Quality Measures

Some opportunities may arise for alignment on quality measures. State Medicaid programs should be aware that MSSP ACOs and their participating providers are reporting or preparing to report eCQMs or MIPS CQMs. The requirement for

ACOs to report these measures on all patients, regardless of the payer, is quite different from expectations for state Medicaid agencies reporting Adult and Child Core Set measures specifically for the Medicaid and CHIP populations, stratified by factors such as race and ethnicity. State Medicaid programs will need to carefully consider the exact measure specifications being used for reporting to assess opportunities for alignment. To assist in that exercise, a crosswalk of Adult Core Set and MSSP measures is provided in Appendix E. The potential for alignment between MSSP and Medicaid quality measures may vary by state. For example, if an ACO's participating providers also care for a substantial portion of the state's Medicaid population, and the ACO works with its providers to improve coding for lab results for patients with diabetes, the state Medicaid program might see better administrative data for the diabetes HbA1c poor control measure.

Create Collective Impact With ACO AIP-Funded Work

Medicaid programs may also find that federal support for ACOs opens doors to collaboration on new initiatives (e.g., AIPs may spark new investments addressing social determinants of health). State Medicaid agencies may find new opportunities for collective impact by working with new MSSP ACOs (e.g., to support community information exchange, or build capacity to address food insecurity). State workforce programs might find opportunities to work with ACOs to increase access in areas with provider shortages. Examples of allowable uses of AIP funds are listed in Appendix C and could be used to start conversations about aligned initiatives. By combining efforts, state agencies and ACOs could make the most of scarce resources to support underserved populations.

CONCLUSION

With changes to MSSP, CMS is making a credible effort to encourage participation by providers who care for underserved populations and create new tools to help address the needs of populations experiencing health inequities. If these change spur new ACO activity, particularly among a state's safety net providers, its Medicaid agency can benefit from awareness of recent changes to the Medicare Shared Savings Program and may wish to explore opportunities for alignment.

Although the nature of the opportunities will vary across states, the MSSP model offers state Medicaid agencies new ways to align with Medicare and increase the impact of their work on payment reform with provider organizations. CMS will publish additional subregulatory guidance in the coming months and could offer new technical assistance to support state understanding of the model's mechanics. By considering how the MSSP model could fit into their state, state Medicaid staff will be well positioned to make the most of new opportunities.

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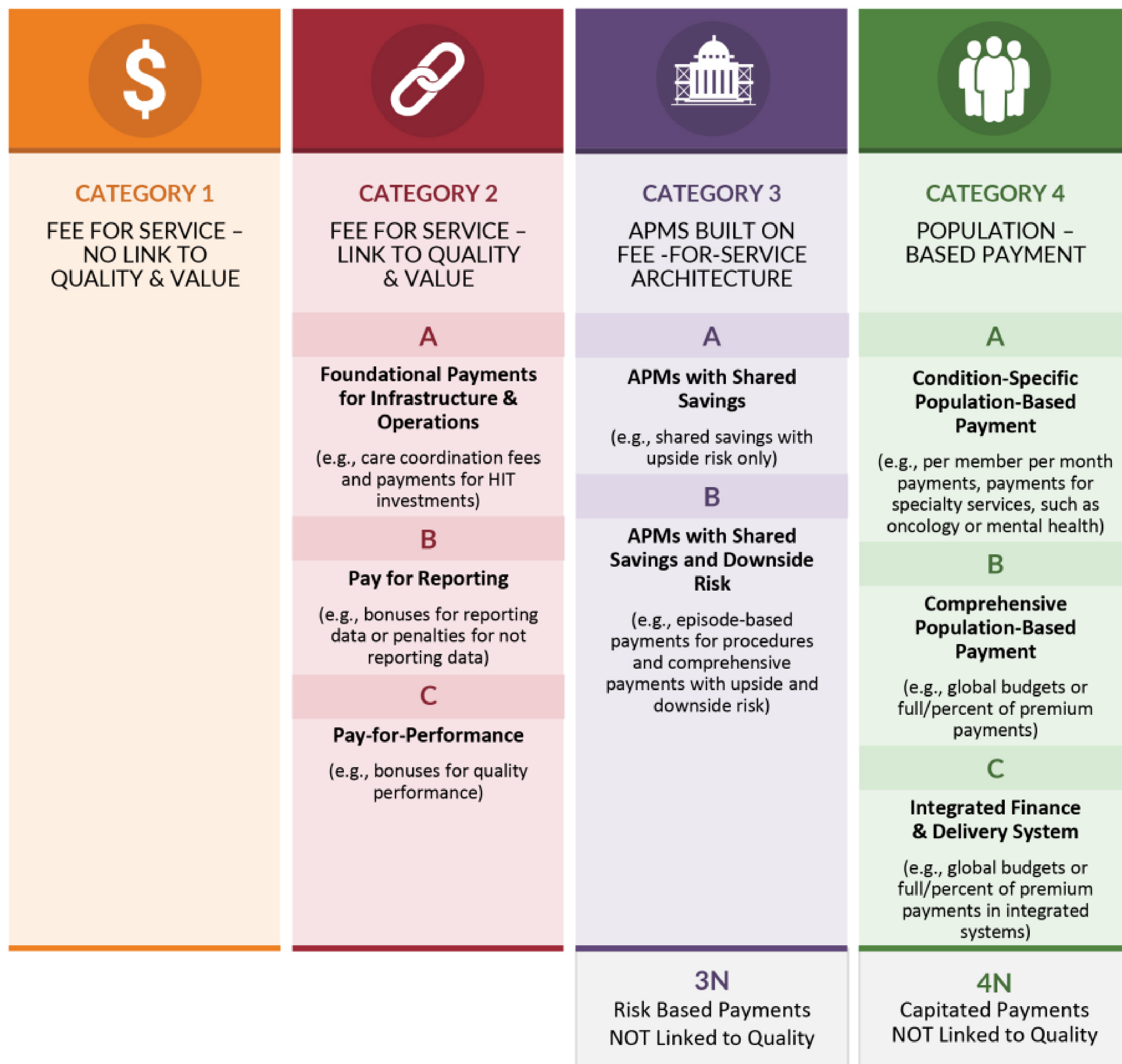
APPENDIX A

HEALTH-CARE PAYMENT LEARNING & ACTION NETWORK (HCP-LAN) ALTERNATIVE PAYMENT MODELS FRAMEWORK

FIGURE A1

HCP-LAN APM Framework



Source. Health Care Payment Learning & Action Network.[9]
Abbreviations. APMs: Alternative Payment Models; HCP-LAN: Health Care Payment Learning & Action Network; HIT: Health information technology.

APPENDIX B

ADDITIONAL RESOURCES

- Centers for Medicare & Medicaid Services. Shared Savings Program: program data. 2022; https://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/program-data. Accessed January 13, 2023.

  This website allows users to explore information about current Medicare Shared Savings Program accountable care organizations (ACOs), including their service areas, start dates, contact information, and public reporting websites. Public use files provide data about financial and quality results, as well as the number of assigned ACO beneficiaries by county. These resources may be useful for state Medicaid agencies that want to know more about ACOs currently operating in their state.

- Medicare Payment Advisory Commission. Payment basics: accountable care organization payment systems. 2022; https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_ACOs_FINAL_SEC.pdf. Accessed December 12, 2022.

  This primer from the Medicare Payment Advisory Commission (MedPAC) provides an overview of accountable care organizations as a payment model. Published in October 2022, the document does not reflect changes in the recently finalized rule, but it is still a useful introduction to ACOs.

- University of Wisconsin School of Medicine and Public Health. Neighborhood atlas. https://www.neighborhoodatlas.medicine.wisc.edu/. Accessed January 13, 2023.

  This website allows users to view maps showing the area deprivation index by state and to download data. The site also includes frequently asked questions. For state officials who want to see which geographic areas have a high area deprivation index percentile, this site would be a worthwhile resource to review.

APPENDIX C

ADVANCE INVESTMENT PAYMENTS: EXAMPLES OF PERMITTED USES

In 2023, the Centers for Medicare & Medicaid Services (CMS) expects to issue subregulatory guidance about permitted uses of advance investment payment (AIP) funds.[4(pp69792)] In the meantime, the recent rule gives examples of how MSSP accountable care organizations (ACOs) may spend AIPs.[4(pp69788-89)]

Increased staffing through partnerships to identify and address social determinants of health (SDOH) or hiring staff:

- Nurse case managers or other support staff to implement SDOH screening;
- Community health workers, certified peer recovery specialists, and other professionals trained in delivering culturally and linguistically tailored services;
- A health equity officer;
- Behavioral health clinicians and case managers to integrate behavioral health care in primary care settings; and
- Oral health providers to integrate dental care in primary care settings.

SDOH strategies related to:

- Transportation services;
- Services to address housing insecurity or homelessness or modify the home or environment to support a healthy lifestyle;
- Legal aid services for social needs;
- Services and supports related to food, employment, utilities, personal safety, social isolation, or financial strain or poverty;
- Patient caregiver supports;
- Providing remote access technologies, telemonitoring, and meals;
- Ensuring access to culturally and linguistically tailored, accessible health care services and supports;
- Partnering with community-based organizations to address SDOH; and
- Implementing systems to provide and track referrals to community-based social services and enable coordinating and measuring health and social care.

Health care provider infrastructure:

- Investment in certified electronic health record technology, including system enhancements and upgrades;
- Connections to clinical data registries and health information exchange;
- Integration of ACO participant systems, including tools to share and analyze operational and quality data;
- Remote access technologies, telemonitoring, screening tools, case or practice management systems for improved care coordination across the health and social care continuum;
- Physical accessibility improvements; and
- Tools to integrate behavioral health or dental services in primary care settings.

APPENDIX D

MSSP QUALITY REPORTING REQUIREMENTS

In these tables from the final rule, CMS summarized the quality performance requirements applicable in 2023 and later years.[4(pp69860, 69862)]

TABLE D1

Final Alternative Payment Model Performance Pathway (APP) Reporting Requirements and Quality Performance Standard for Performance Year 2023 and Subsequent Performance Years[4(pp69860)]

	Performance Year 2023	Performance Year 2024	Performance Year 2025 and Subsequent Performance Years*
Shared Savings Program ACO Quality Reporting requirements	ACOs are required to report the 10 measures under the CMS Web Interface or the 3 eCQMs/MIPS CQMs and administer the CAHPS for MIPS survey. CMS will calculate the two claims-based measures.	Same as PY 2023	ACOs are required to report on the 3 eCQMs/MIPS CQMs and field the CAHPS for MIPS survey. CMS will calculate the two claims-based measures.
Shared Savings Program ACO Quality Performance Standard	Achieving a health equity adjusted quality performance score that is equivalent to or higher than the 30th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility based-scoring; or Reporting the three eCQMs/MIPS CQMs in the APP measure set, meeting the data completeness requirement for all three eCQMs/MIPS CQMs, achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the f our outcome measures in the APP measure set and a quality performance score equivalent to or higher than the 30th percentile of the performance benchmark on at least one of the remaining five measures in the APP measure set, or An ACO that fails to meet either of the criteria above but meets the alternative quality performance standard by achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set would share in savings (if otherwise eligible) at a lower rate that is scaled by the ACO's quality performance score. If an ACO (1) does not report any of the ten CMS Web Interface measures or any of the three eCQMs/MIPS CQMs and (2) does not administer a CAHPS for MIPS survey under the APP, the ACO will not meet the quality performance standard or the alternative quality performance standard.	Achieving a health equity adjusted quality performance score that is equivalent to or higher than the 40th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility based-scoring, or Reporting the three eCQMs/MIPS CQMs in the APP measure set, meeting the data completeness requirement and the case minimum requirement for all three eCQMs/MIPS CQMs, achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set and a quality performance score equivalent to or higher than the 40th percentile of the performance benchmark on at least one of the remaining five measures in the APP measure set, or An ACO that fails to meet the criteria above but meets the alternative quality performance standard by achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set would share in savings (if otherwise eligible) at a lower rate that is scaled by the ACO's quality performance score. If an ACO (1) does not report any of the ten CMS Web Interface measures or any of the three eCQMs/MIPS CQMs and (2) does not administer a CAHPS for MIPS survey under the APP, the ACO will not meet the quality performance standard or the alternative quality performance standard.	Achieving a health equity adjusted quality performance score that is equivalent to or higher than the 40th percentile across all MIPS Quality performance category scores, excluding entities/providers eligible for facility based-scoring, or An ACO that fails to meet the criterion above but meets the alternative quality performance standard by achieving a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set would share in savings (if otherwise eligible) at a lower rate that is scaled by the ACO's quality performance score. If an ACO (1) does not report any of the three eCQMs/MIPS CQMs and (2) does not administer a CAHPS for MIPS survey under the APP, the ACO will not meet the quality performance standard or the alternative performance standard.

* The CMS Web Interface reporting option sunsets after PY 2024 and is no longer available beginning with PY 2025.
Source. Centers for Medicare & Medicaid Services[4(pp69860)]
Abbreviations. ACO: accountable care organization; CMS: Centers for Medicare & Medicaid Services; eCQM: electronic clinical quality measure; MIPS: Merit-based Incentive Payment System; CQM: clinical quality measure; CAHPS: Consumer Assessment of Healthcare Providers and Systems; APP: Alternative Payment Model Performance Pathway.

TABLE D2

Measures Included in the Final APM Performance Pathway Measure Set (APP) for Performance Year 2022 and Subsequent Performance Years[4(pp69862)]

Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measures 2.0 Area	Measure Type
Quality ID#: 321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary	Person-Centered Care	PRO-PM*
Measure # 479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Affordability and Efficiency	Outcome^
Measure # 484	Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions	Administrative Claims	N/A	Affordability and Efficiency	Outcome^
Quality ID#: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM/ CMS Web Interface**	APM Entity/Third Party Intermediary	Chronic Conditions	Intermediate Outcome^
Quality ID#: 134	Preventative Care and Screening for Depression and Follow-up Plan	eCQM/MIPS CQM/ CMS Web Interface**	APM Entity/Third Party Intermediary	Behavioral Health	Process
Quality ID#: 236	Controlling High Blood Pressure	eCQM/MIPS CQM/ CMS Web Interface**	APM Entity/Third Party Intermediary	Chronic Conditions	Intermediate Outcome^
Quality ID#: 318	Falls: Screening for Future Fall Risk	CMS Web Interface**	APM Entity/Third Party Intermediary	Safety	Process
Quality ID#: 110	Preventative Care and Screening: Influenza Immunization	CMS Web Interface**	APM Entity/Third Party Intermediary	Wellness and Prevention	Process
Quality ID#: 226	Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention	CMS Web Interface**	APM Entity/Third Party Intermediary	Behavioral Health	Process
Quality ID#: 113	Colorectal Cancer Screening	CMS Web Interface**	APM Entity/Third Party Intermediary	Wellness and Prevention	Process
Quality ID#: 112	Breast Cancer Screening	CMS Web Interface**	APM Entity/Third Party Intermediary	Wellness and Prevention	Process
Quality ID#: 438	Statin Therapy for the Prevention and Treatemnt of Cardiovascular Disease	CMS Web Interface**	APM Entity/Third Party Intermediary	Chronic Conditions	Process
Quality ID#: 370	Depression Remission at Twelve Months***	CMS Web Interface**	APM Entity/Third Party Intermediary	Behavioral Health	Outcome^

For Performance Year 2022, CMS will not score 2 of the Web Interface measures, Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Quality ID #438) and Depression Remission at 12 Months (Quality ID #370), because these measures do not have benchmarks. The measures are required to be reported to complete the Web Interface data set.
^ Indicates this is an outcome measure.
* Patient-reported outcome-based performance measure (PRO-PM) is a performance measure that is based on patient-reported outcome measure (PROM) data aggregated for an accountable healthcare entity.
** ACOs will have the option to report via the Web Interface for the 2022, 2023, and 2024 performance years only.
*** 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.
Source. Centers for Medicare & Medicaid Services[4(pp69862)]
Abbreviations. CAHPS: Consumer Assessment of Healthcare Providers and Systems; MIPS: Merit-based Incentive Payment System; PRO-PM: Patient-reported outcome-based performance measure; eCQM: electronic clinical quality measure; CQM: clinical quality measure; CMS: Centers for Medicare & Medicaid Services; APM: alternative payment model.

APPENDIX E

CROSSWALK OF MSSP AND MEDICAID ADULT CORE MEASURES

This table compares the Medicare Shared Savings Program (MSSP) measure set containing electronic clinical quality measures (eCQMs) and Merit-based Incentive Program clinical quality measures (MIPS CQMs) with the Medicaid Adult Core Set measures for 2023 and 2024. Starting with reporting due in 2024 (reflecting performance in calendar year 2023), state Medicaid programs must report all of the behavioral health measures in the Adult Core Set and all measures in the Child Core Set. The table also includes notations for measures within Centers for Medicare & Medicaid Services' (CMS's) recently published list of "universal foundation" measures.[19]

For Adult and Child Core Set reporting, state agencies must report on Medicaid and CHIP beneficiaries only. As noted above, an MSSP accountable care organization (ACO) must report the MIPS CQMs or eCQMs on an all-payer basis, including all patients seen by the ACO's participating provider.

For the reader's convenience, the table includes links to the CMS Measure Inventory Tool for details about the MSSP measures.

TABLE E1

Crosswalk of Medicare Shared Savings Program (MSSP) and Medicaid Adult Core Measures

Measure Name	CMS Universal Foundation	Adult Core Set Domain	Adult Core Set Data Collection	MSSP Data Collection
Hospital-wide, 30-day, All-cause, Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Yes			Administrative
Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions				Administrative
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	Yes	Behavioral Health Care	Administrative or EHR (eCQM)	MIPS CQM or eCQM
Controlling High Blood Pressure (CBP-AD)	Yes	Care of Acute and Chronic Conditions	Administrative, hybrid, or EHR (eCQM)	MIPS CQM or eCQM
Hemoglobin A1c Control for Patients With Diabetes (HBD-AD) *Note: This measure has 2 rates:* • HbA1C Control (<8%) • HbA1C Poor Control (>9%)	Yes, for one rate of combined measure	Care of Acute and Chronic Conditions	Administrative, hybrid, or EHR (eCQM)	
Hemoglobin A1c Poor Control (>9%)	Yes			MIPS CQM or eCQM
Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS	Yes			Survey
CAHPS Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA-AD)	Yes	Experience of Care	Survey	
Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	Yes	Behavioral Health Care	Administrative or EHR (eCQM)	

Measure Name	CMS Universal Foundation	Adult Core Set Domain	Adult Core Set Data Collection	MSSP Data Collection
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)		Behavioral Health Care	Survey	
Antidepressant Medication Management (AMM-AD)		Behavioral Health Care	Administrative or EHR (eCQM)	
Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)		Behavioral Health Care	Administrative	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)		Behavioral Health Care	Administrative	
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)		Behavioral Health Care	Administrative or hybrid	
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)		Behavioral Health Care	Administrative	
Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD)		Behavioral Health Care	Administrative	
Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)		Behavioral Health Care	Administrative	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)		Behavioral Health Care	Administrative	
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 18 and Older (AAB-AD)		Care of Acute and Chronic Conditions	Administrative	
PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)		Care of Acute and Chronic Conditions	Administrative	
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)		Care of Acute and Chronic Conditions	Administrative	
PQI 08: Heart Failure Admission Rate (PQI08-AD)		Care of Acute and Chronic Conditions	Administrative	
PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)		Care of Acute and Chronic Conditions	Administrative	
Plan All-Cause Readmissions (PCR-AD)	Yes	Care of Acute and Chronic Conditions	Administrative	
Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)		Care of Acute and Chronic Conditions	Administrative	
HIV Viral Load Suppression (HVL-AD)		Care of Acute and Chronic Conditions	Administrative or EHR (eCQM)	

Measure Name	CMS Universal Foundation	Adult Core Set Domain	Adult Core Set Data Collection	MSSP Data Collection
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)		Care of Acute and Chronic Conditions	Administrative	
Concurrent Use of Opioids and Benzodiazepines (COB-AD)		Care of Acute and Chronic Conditions	Administrative	
Long-Term Services and Supports Comprehensive Care Plan and Update (CPU-AD)		Long-Term Services and Supports	Case management record review	
National Core Indicators Survey (NCIDDS-AD)		Long-Term Services and Supports	Survey	
Prenatal and Postpartum Care: Postpartum Care (PPC-AD)		Maternal and Perinatal Health	Administrative or hybrid	
Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)		Maternal and Perinatal Health	Administrative	
Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)		Maternal and Perinatal Health	Administrative	
Cervical Cancer Screening (CCS-AD)		Primary Care Access and Preventive Care	Administrative, hybrid, or EHR (eCQM)	
Chlamydia Screening in Women Ages 21 to 24 (CHL-AD)		Primary Care Access and Preventive Care	Administrative or EHR (eCQM)	
Colorectal Cancer Screening (COL-AD)	Yes	Primary Care Access and Preventive Care	Administrative or EHR (eCQM)	
Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)		Primary Care Access and Preventive Care	Survey	
Breast Cancer Screening (BCS-AD)	Yes	Primary Care Access and Preventive Care	Administrative or EHR (eCQM)	

Abbreviations. CMS: Centers for Medicare & Medicaid Services; MSSP: Medicare Shared Savings Program; MIPS: Merit-based Incentive Payment System; EHR: electronic health record; eCQM: electronic clinical quality measure; CQM: clinical quality measure; PQI: prevention quality indicator.

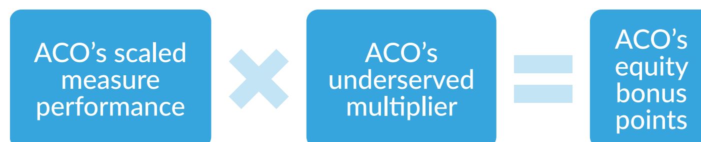
APPENDIX F

HEALTH EQUITY BONUS POINT CALCULATION

As explained in the recently finalized rule,[4(pp69856)] the calculated equity bonus points are the product of the ACO's scaled measure performance and the ACO's underserved multiplier (Figure F1).

FIGURE F1

Health Equity Bonus Point Calculation



Abbreviation. ACO: accountable care organization.

The scaled measure performance score is calculated for each of the 6 measures:

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS) for Merit-based Incentive Payment System (MIPS) (survey);
2. Hospital-wide, 30-day, all-cause unplanned readmission (HWR) rate for MIPS eligible clinician groups (administrative claims outcome measure);
3. Clinician and clinician group risk-standardized hospital admission rates for patients with multiple chronic conditions (administrative claims outcome measure);
4. Diabetes HbA1c poor control (eCQM or MIPS CQM intermediate outcome measure);
5. Preventive care and screening: screening for depression and follow-up plan (eCQM or MIPS CQM process measure); ***and***
6. Controlling high blood pressure (eCQM or MIPS CQM intermediate outcome measure).

An ACO receives a score of 0 on a measure for failure to meet reporting requirements, such as case minimum and survey minimum sample size requirements. The ACO still may receive equity points for the other measures in the set. Points are awarded as shown below (Table F1).

The scaled score is then multiplied by the underserved multiplier. If an ACO's underserved multiplier is below the 20% floor, the ACO receives no bonus points. As long as the ACO reaches the floor of 20%, the underserved multiplier is the higher of:

- The proportion of the ACO's assigned beneficiaries who are enrolled in the Medicare Part D low income subsidy (LIS) or are dually eligible for Medicare and Medicaid; ***or***
- The proportion of the ACO's assigned beneficiaries who reside in a census block group where the area deprivation index (ADI) has a national percentile rank of at least 85.

TABLE F1

Health Equity Bonus Point Scale for Measure Performance

ACO's performance on each measure, as compared to other ACOs	Points awarded for the measure
Performance in top third	4
Performance in middle third	2
Performance in bottom third	0

Abbreviation. ACO: accountable care organization.

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