The 2024 CMS PFS Final Rule: Post-PHE, Value-Based Care Returns to the Forefront

written by Dave Halpert | November 9, 2023

The 2024 Physician Fee Schedule Final Rule—all 2,709 pages worth—was released on November 3, and the significance of the "Post-COVID" rule cannot be understated. With the Public Health Emergency expiring earlier this year, these finalized policies are intended to get the proverbial train back on its tracks, following the massive derailment in March 2020.

Although many policies were finalized as proposed, there are plenty of exceptions and caveats, and providers and practices need to be keenly aware of the details. CMS is using this rule to advance its value-based care goals through data aggregation and attention to health equity. Those who simply stay the course will find unwelcome surprises in their reimbursements, referrals, and market presence.

The flip side of that coin is that this Rule creates opportunity for providers to transform healthcare on their own terms, rather than simply following rules handed down from public and private health plans. Organizations and providers should consider five key themes in this Rule as they develop and refine their value-based care strategies for 2024 and beyond.

1. The Traditional MIPS Pot is Near the Boiling Point – Hop Out Now!

CMS continues to trumpet its goal of having all Medicare patients in an accountable care relationship with a provider responsible for Total Cost of Care by 2030. Traditional MIPS is a barrier to that goal, and policies within this Rule are intended to move providers out of that system in advance of a to-be-determined Traditional MIPS sunset date.

The strategy is two-fold: The first is to broaden the MIPS Value Pathway (MVP) library, facilitating greater participation among MIPS-eligible clinicians. The second is to add challenges to Traditional MIPS, making it a less attractive option.

MIPS Value Pathways (MVPs) are intended to streamline MIPS by limiting providers to more specific and relevant sets of quality and cost measures. This will facilitate more meaningful comparisons between providers than Traditional MIPS, as providers—especially specialists—can "fly below the radar," being scored on measures reported by others in the practice. For 2024, CMS has finalized five new MVPs, which brings the total to 16:

> Focusing on Women's Health
> Prevention and Treatment Infectious Disorders Including Hepatitis C and HIV
> Quality Care in Mental Health and Substance Use Disorders
> Quality Care for Treatment of Ear, Nose and Throat (ENT) Disorders
> Rehabilitative Support for Musculoskeletal Care

On the Traditional MIPS front, the biggest challenge will be the raised data completion threshold for quality measures. In 2024, for a quality measure to be scored, there must be a response for at least 75 percent of the eligible denominator, up from 70 percent over the last several years. It sounds like a very small adjustment, but for some measures, this can mean hundreds, or even thousands of additional responses.

In addition to reporting on more patients, the annual process of quality measure deletions, additions, and substantial changes make it impossible to devise a reporting strategy that lasts longer than one year. The measure benchmarks are still to be determined, as well, meaning that even if you do have measures that work in both 2023 and 2024, there is no guarantee that a score earning top marks in 2023 will do so in 2024, even if your performance is consistent.

2. Advancing Health Equity

Health Equity policies are primarily found in the Accountable Care Organization (ACO) section

of the Rule, as CMS believes that one of the most critical strategies for advancing health equity is to ensure that all patients are in accountable care relationships.

This is also a multi-pronged strategy, utilizing updates to cost-benchmarking methodology, Advanced Incentive Payments, changes to the attribution model, and incentivization of all patient reporting.

To the delight of ACOs, the regional benchmark adjustments were finalized as proposed. HCC risk growth on the ACO's Service Area is capped between PY1 and PY3, independently of the ACO. This means that the regional component of the ACO's benchmark is increased when the ACOs serve areas with prospective HCC scores above the cap. The result is that ACOs can thrive in regions with proportionately more high-risk beneficiaries, which will encourage the formation of new ACOs and the expansion of existing ACOs.

Updates to the Advanced Incentive Payment (AIP) structure is also intended to drive ACO participation and link more patients to accountable care relationships. Previously, ACOs could only be in a one-sided arrangement for the duration of the agreement if receiving AIPs. Those who understood how they could generate significant savings (in excess of AIP revenue) were barred from doing so, unless they were willing to immediately repay these AIPs to CMS. This Rule allows AIP recipients to take on risk in their third year. These ACOs will still have to pay the AIPs back through subsequent earnings of shared savings, but that's less jarring than an immediate recoupment, and they can still come out ahead. The slower payback period and opportunity for additional upside revenue is sure to entice new entrants.

ACO attribution is also used to advance health equity. The Rule finalizes (as proposed) attribution changes that account for the role NPs, PAs, and CNSs play in primary care delivery. This will also increase the number of underserved beneficiaries who would be able to receive care through an ACO. In prior years, these patients would have been excluded, and it is anticipated that the incorporation of these patients will generate a 1.3 percent increase in beneficiaries attributed to ACOs. Although this will not take effect until 2025, ACOs should plan now for changes to their patient mix.

Quality reporting changes are also tied to advancing health equity. ACOs who adopt APM Performance Pathway (APP) Reporting, regardless of whether using Electronic Clinical Quality Measures (eCQMs), MIPS CQMs or Medicare CQMs, are eligible to earn additional points to their quality scores through a Health Equity Adjustment. Furthermore, to account for the breadth of the eligible population, performance standards are relaxed— an ACO that achieves the tenth performance percentile in one of the APP outcome measures can still earn shared savings.

3. Bringing Specialty Providers into Value-Based Care Efforts

When looking at Total Cost of Care, the focus is understandably on the primary care providers who are managing their patients' care. While data-driven strategies can help you identify which providers have historically superior outcomes in acute and procedural episodes, the specialist role has not been as visible, particularly in ACOs comprised of large, multi-specialty practices. In the APP, for example, quality reporting consists of three measures, all of which are driven by primary care.

To highlight specialty care in ACOs, CMS floated a potential quality bonus for specialists within an ACO who also report MIPS Value Pathways. The goal would be to enable both patients and ACO participants to compare specialty care outcomes at a more granular level than is feasible now. There were no specifics in the Proposed Rule to finalize here, but CMS did use this Rule to solicit specific feedback on implementation, payment adjustments, and more. ACOs looking to stay ahead of the curve should take note!

For specialists participating in MIPS, CMS has added five specialty-specific cost measures. In MIPS, unless a provider has a minimum case number of patients meeting a cost measure (it varies by measure), the measure cannot be scored. The provider's cost score becomes dependent on a general cost measure, rather than a more specific and meaningful measure. These five new cost measures ensure that providers who treat depression, heart failure, low back pain, or psychoses, or who practice emergency medicine are assessed on more relevant criteria.

4. CMS Continues to Push Data Integration

The sunset of the CMS Web Interface for ACO quality reporting has catapulted data integration into the spotlight. Rather than reporting on a sample of 248 patients per measure, the APP looks at the total population across three measures. The relatively small Web Interface sample meant that ACOs could manually scour records and enter results. No more!

As we have described, there are too many patients for that process to work. Furthermore, because the measures must be reported at the unique patient level and include the most recent value, adding QRDA results between practices is not an acceptable option.

ACOs have pushed back against this, as there is a persistent myth that data aggregation is prohibitively expensive and time consuming. As a concession, CMS developed the Medicare CQM option for ACOs, allowing them to report on the three APP measures, but only for Medicare

patients. The Final Rule even created a provision wherein the ACO will have access to their complete denominator, which was not available in the initial proposal.

Nevertheless, the need for data aggregation still exists. With ACOs treating tens (and sometimes hundreds) of thousands of Medicare patients, the sheer volume of patients precludes the manual chart-by-chart approach. Regardless of APP reporting method, ACOs with disparate EHRs will need a data aggregation solution to succeed in APP reporting and remain eligible for shared savings.

The Promoting Interoperability (PI) category, worth 25 percent of the total MIPS score, is also featured in the Rule. CMS finalized the policy that, rather than a 90-day minimum performance window, the PI performance period must last for a minimum of 180 consecutive days. The implications go beyond MIPS—with Advanced APMs and ACOs on the cusp of having to require 100 percent CEHRT participation amongst participants and report PI, those without CERHT who want to participate in an APM will have less time to implement CEHRT than previously thought.

5. One-Year Delays are for Transitions—Don't Procrastinate!

Several proposals will not take effect in 2024 in order to give organizations the lead time they need to prepare.

The first is that the MIPS Performance Threshold will remain at 75 points, rather than being bumped up to 82. CMS was swayed by comments that many have been on a 3-year MIPS hiatus during the PHE, and even the existing 75-piont threshold is higher than it was in 2020. Forcing a reengagement in conjunction with an even higher performance standard all but doomed those coming back into the fold. It was also noted that there was a self-selecting group who continued to report during a time when Extreme and Uncontrollable Circumstance (EUC) exemptions were so easy to come by. This artificially inflates MIPS scores, and so a policy of looking at prior periods to determine a performance standard is inherently flawed.

For ACOs, there are also policy delays. One concerns the mandatory CERHT requirement for participants in Advanced APMs and ACOs. This will not take effect until 2025, putting it in sync with the elimination of the CMS Web Interface for Quality Reporting. The result is that ACOs have a one-year transition period before being put on a mandatory path to digital quality measurement.

The change to the patient attribution policy described previously will also be delayed for one year. Although CMS does not anticipate that incorporating care from NPs, CNSs, and PAs (rather

than just physicians) will cause large-scale changes for ACOs, they are providing an extra year to account for unintended downstream effects.

The most notable consequence stems from CMS's inability to distinguish whether NPs, PAs, and CNSs are providing primary care, or specialty care. Bringing them into the attribution methodology exacerbates a known issue in beneficiary assignment. Specialty practices with a high volume of non-physician practitioners have been hit particularly hard in total cost of care measures, as so many of their attributed beneficiaries with chronic conditions are not being managed by that practice, or are going to be high-cost based on the nature of the care they receive at the specialty practice (a PA at an oncology practice, for example).

Furthermore, since many of these patients are being seen for acute conditions, they will not be included in the ACO's population in subsequent years, making it impossible for the ACO to develop effective care coordination strategies.

These policies are bound to cause some growing pains, and the best way to mitigate them is to being the process now. There will be unexpected challenges, and those who have addressed them in advance are poised to succeed at the expense of those who have not.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Ladd Green