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

written by Dave Halpert | November 11, 2024



The 2025 CMS PFS Rule landed with a bang, and it's not just the weight of the 3,088 pages.

We're one year closer to 2030, the year that CMS intends to have all Traditional Medicare patients in a relationship with a clinician who is accountable for total cost of care. The push to the finish line is the primary driver behind each of the QPP-related policies in this Rule. For CMS to accomplish its goal within its stated time-frame, accountable care programs must promote equity, expand into rural and underserved areas, and align to reduce administrative burden.

A slew of new rules will take effect in just two short months, and those who aren't familiar with the changes and the reasoning behind them will find themselves fighting to keep afloat as these updates and downstream consequences are felt. Here are the five key policies you need to understand, as they can determine whether your value-based care journey brings

payments or penalties.

1. Rewarding High-Performing ACOs with Prepaid Shared Savings

To address ongoing maintenance costs and facilitate continuous improvement, CMS has approved its Prepaid Shared Savings proposal. ACOs who have a track record of earning shared savings, and who are in a two-sided model (BASIC C-E or ENHANCED tracks), have the opportunity to receive an advance on potential shared savings and reinvest them in the ACO and its patients. At least half of these Prepaid Shared Savings must go to direct beneficiary services that aren't already paid by CMS, and, of course, they must be evidence-based and appropriate, depending on the individual beneficiary's clinical and social risk factors.

The remaining Prepaid Shared Savings may be spent on staffing and, importantly, on investments to health care infrastructure. This gives you the opportunity to partner with a data analytics and aggregation vendor who will identify your pain points and give you the tools to address them.

Prepaid Shared Savings fall into CMS's larger strategy of prioritizing primary care through other programs like ACO PC FLEX and the Making Care Primary (MCP) Model. In addition to program-specific guidance, the Accountable Care coverage umbrella will be further extended through the introduction of Advanced Primary Care Management (APCM) services. The purpose is to facilitate the delivery of advanced primary care, particularly as APCM services relate to managing principal care, transitions, and chronic conditions. These are intended to pay for primary care in a hybrid model (i.e. population-

based payments and payments for encounters), rather than strictly Fee for Service.

2. Incentives for ACOs in Rural and Underserved Communities

In order to ensure that all Traditional Medicare beneficiaries are in an accountable care relationship, support for ACOs in rural and underserved areas is critical. To entice providers in these areas, CMS has finalized its proposed Health Equity Benchmark Adjustment (HEBA).

The HEBA is calculated based on the proportion of beneficiaries who are enrolled in the Medicare Part D Low Income Subsidy (LIS) or who are dually eligible for Medicaid and Medicare. The HEBA will be a third method for increasing an ACO's historical benchmark.

In other words, an ACO will be able to spend more on patient care before crossing from shared savings into shared losses. The HEBA will also offset the Congressional Budget Office finding that ACOs launching in rural and underserved communities have higher start-up costs than their peers. Furthermore, this will help to mitigate the historically (and unfortunately) low health care spending trends in rural and underserved communities.

3. Termination Protections for Small ACOs

For small ACOs in rural and underserved areas, CMS is adding an element of stability through updates to its policy regarding minimum beneficiary count. Currently, an ACO must have at least 5,000 assigned beneficiaries by the end of the performance

year, and those who don’t must create and fulfill a Corrective Action Plan (CAP) to bring that number up—or face automatic termination. There were 24 ACOs between 2020 and 2023 that were affected by this policy. After CMS enforced the existing requirements, more than half of those ACOs chose to voluntarily terminate ahead of their Corrective Action Plan (CAP) deadline, taking patients out of accountable care relationships, rather than putting them in.

Here’s the problem: the fewer the beneficiaries, the less reliable the calculations for Minimum Savings Rate (MSR) and Minimum Loss Rate (MLR). In other words, without a sufficient sample of beneficiaries, there isn’t a reliable way to measure whether the ACO is reducing spending and improving quality.

However, in recent years, CMS has been able to calculate MSR and MLR on a sliding scale, based on the number of beneficiaries within the ACO. CMS says that this has proven to be an effective guardrail against making overpayments and underpayments, and it is reliable enough to inform whether to reconsider actions taken when an ACO’s beneficiary count falls below 5,000. Rather than an automatic termination following the end of the CAP, CMS may take a more flexible approach, which facilitates CMS’s goal of increasing the number of existing ACOs and their beneficiaries.

4. Shaking Up ACO Quality Reporting (Again)

In the Proposed Rule, CMS outlined its plans to align quality reporting requirements in its programs using the Universal Foundation of Measures.

They’ve codified that process here, creating an APP Plus

Measure Set (APP Plus), which will expand each year, beginning in 2025 with a fourth measure: Breast Cancer Screening. The expansion of the APP Plus measure set may seem daunting, but those who utilize the additional information to help control patient care costs will reap additional benefits. The APP Plus measures will all be reportable through Medicare CQMs, eCQMs, *and* . . . MIPS CQMs.

Yes, CMS has walked back from its proposal to eliminate the MIPS CQM reporting option in the APP Plus, as many ACOs have already developed or contracted with entities to report MIPS CQMs. We are thrilled with this decision; as we described, the QRDA files behind eCQM reporting have limited value and are often unreliable, as they do not account for variations in documentation that can occur between providers (even if they're in the same office!).

The MIPS CQM collection type has been granted a reprieve for 2025 and 2026, which will enable ACOs to gain more experience in all-payer reporting, and to do so when the APP Plus Measure Set is smaller than its eventual iteration. MIPS CQMs will also be folded back into the all-patient reporting incentive, wherein an ACO can meet the Quality Standard (earn shared savings) under a more lenient scoring methodology.

Although CMS has temporarily brought MIPS CQMs back into play, they make no secret that they've pinned their future quality reporting requirements on eCQMs, and are incentivizing their use through a Complex Organization Bonus, adding points for measures submitted as eCQMs.

Although eCQMs are not currently optimized for Digital Quality

Measures (dQMs), CMS believes the Fast Healthcare Interoperable Resource (FHIR) standard will gain widespread use over the next five years, facilitating that transition. Interestingly, although CMS cites a 5-year estimate for FHIR adoption, the MIPS CQM option is only granted a two-year extension.

The third reporting option, Medicare CQMs, receive treatment in the Rule, as well. Since these measures have only been scored using the Web Interface and all-patient submissions, there was a question about how they would be benchmarked when reported for all eligible attributed ACO patients. Until a reliable benchmark is created, Medicare CQMs will be scored using "flat" benchmarks (i.e. 10 points for performance greater than 90 percent, 9 points for performance between 80 and 89.99, etc.) so that ACOs with the ability to aggregate data from their disparate EHRs can reliably estimate performance and identify areas for improvement.

5. MVPs: The Ulterior Motive Behind Favorable MIPS Policies

There are fewer shake-ups on the MIPS side of the QPP house; the major proposals from this summer have all been finalized. The result is that MIPS retains an element of stability. But don't be lulled into complacency—the reasoning behind this consistency (for now) is to offer a firm jumping-off point for providers and organizations to transition to MVPs or Advanced Alternate Payment Models (APMs), including ACOs.

In the short-term, though, MIPS participants can breathe a sigh of relief that the minimum performance threshold for MIPS remains at 75 points, rather than the anticipated 82 that was floated last year. The data completion threshold for quality

measures is also frozen at 75 percent, all the way through the 2028 performance period. As an added bonus, Improvement Activities are shifting from a weighted, point-based approach to a simple count—those who complete two Improvement Activities will earn full Improvement Activity credit. Promoting Interoperability requirements are also unchanged.

That leaves the Cost component. Cost has hit MIPS participants especially hard; with the category being re-weighted in prior years, providers did not have a good feel for how they would score, or what they needed to do to improve. Once Cost was rolled into the MIPS score, providers saw it to be the biggest obstacle to clearing the Minimum Performance Threshold, and also the most opaque. With Cost accounting for 30 percent of the MIPS score, even perfect performance in the other three categories cannot guarantee protection against penalties. Using the existing scoring standard, that is not as hyperbolic as it sounds.

By approving the proposed scoring updates for Cost measures, CMS has eased those pains. Rather than the existing performance benchmark policy, the new methodology is tied to the median (50th percentile) score and standard deviations. The result is that providers who score in the middle of the pack are not disproportionately punished and pulled below the Minimum Performance Threshold. As an added bonus, CMS is implementing this policy beginning with the current (2024) performance period, as scores will not be calculated until 2025, and therefore, can be codified in the 2025 Rule.

As good as this sounds, it is not a permanent reprieve. As groups ramp up their efforts to understand the reasons for

variations and begin to make improvements, those who don't will see the low Cost scores that plagued them before.

To increase MVP participation among specialists, certain (but not all) topped-out measures will have their 7-point caps removed so that specialty providers can report on clinically relevant measures without seeing their quality scores artificially cut down. The hope is that this will remove a barrier to specialists participating in MVPs so that consumers can make meaningful comparisons using CMS's public reporting tools. This would correct an existing issue in which specialists, especially those in multi-specialty groups, can skate by on the Quality component of MIPS by reporting measures that do not accurately measure quality of care.

With the quality measures addressed, CMS can move onto the next barrier it faces when creating specialty-centric MVPs: identifying cost measures that are directly attributable to a specific clinician. For that reason, there will be continued development of new cost measures, which will be utilized in both Traditional MIPS and an applicable MVP. The 2025 performance year is no exception, and six new episodic cost measures are being rolled out. Of these, five are chronic condition-based, and will be triggered with 20 eligible cases. The remaining measure is a procedural measure, and only requires 10 eligible cases for automatic scoring. For 2025, that brings the total to 33 episode-based cost measures and two population-based cost measures.

Although there is a lot in this Rule that supports MIPS participation, ongoing program maintenance leads to uncertainty. For example, a whopping 66 measures have received

substantive changes, which makes predictions difficult and could impact existing workflows. Two of them have an even greater impact, as they are both in the APP Plus measure set. Once measure specifications are released (before the start of the performance period is all we know!), organizations should study these (and all other changes within this Rule) carefully to avoid pitfalls.

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