

The 2024 CMS PFS Proposed Rule: 7 Attempts to Balance Participation Goals with Value

written by Dave Halpert | July 19, 2023



Reading between the many lines in the 1,920-page [2024 Medicare Physician Fee Schedule \(PFS\) Proposed Rule](#), one thing is clear: CMS is still struggling to move providers into Advanced Alternate Payment Models (APMs) and keep existing ACOs moving forward on the path to value-based payments. The APP Reporting tug-of-war between CMS and ACOs results in a slight concession for providers worried about difficulty and cost of all-patient APP Reporting.

We've seen this before, of course. Remember the delay in [sunsetting the Web Interface for ACOs](#) in the 2022 Rule and the [retreat from mandatory transition to risk](#) in the 2023 Rule? This year is no different.

The concession in the 2024 Proposed Rule is a new data submission type for ACOs: Medicare Clinical Quality Measures (Medicare CQMs). These measures will allow ACOs to report via the

APP, but in a manner that only includes Medicare patients. While a seeming departure from previous APP guidance, Medicare CQMs are less of an about-face than they initially seem. As we know, the devil is in the details, and Medicare CQMs are just one of the seven key components in this Proposed Rule that walk the line between participation goals and value.

[Click here for a one page summary of the Proposed Rule.](#)

1. Medicare Clinical Quality Measures: A Superficial Concession—Read the Fine Print!

Medicare Clinical Quality Measures are the headliner of this year's Proposed Rule. Even though it is in your ACO's best interest to [aggregate the entirety of your practices' data](#), the ACO community has steadfastly opposed all-patient reporting via the Alternate Payment Model Performance Pathway, or [APP](#).

As a compromise, CMS has introduced the concept of the Medicare Clinical Quality Measures. At first pass, this data submission type seems like a complete reversal. But watch out! Even if you choose to report Medicare CQMs, your ACO will still need an [APP strategy built on data aggregation](#). Here's why:

Medicare CQMs are the same measures as those in the existing APP, with one critical difference. Despite the language in the [2021 CMS Innovation Center's Strategic Refresh](#) advocating for increasing beneficiary participation—including non-Medicare Fee For Service (FFS) Patients—Medicare CQMs will only encompass Medicare FFS patients, and only those who have encounters with the types of providers driving patient alignment to the ACO (i.e. a primary care provider) and who had a claim during the measurement period. This second condition is meant to prevent measure eligibility when a specialist triggers the measure, but where the ACO doesn't have a primary care relationship with the patient. As an additional concession to ACOs, CMS indicates that it will share a list of the eligible patients at the beginning of the submission period.

The use of claims data might seem to be sufficient to provide all the denominator data (eligible patients) required for APP Reporting. You might think you could delay aggregating provider data indefinitely. But here's where the fine print kicks in. The list that CMS provides will most likely be incomplete. Further, except for very small ACOs, it will still be too large for manual data collection of quality measure values for those eligible patients.

There is a run-out period on Medicare claims, so a denominator list on patients at the beginning of the submission period (January 1, 2025) will not include all patients meeting denominator

criteria in 2024. The Proposed Rule explicitly states that ACOs will still be on the hook for some of their own denominator identification.

Those who only report back on the list of patients they receive are showing their cards, admitting that they have not reported on the complete 12-month performance period. While the data completion threshold is 75 percent, it cannot be used to circumvent reporting on a complete denominator. In other words, yes, it's mathematically probable that if you report on 100 percent of patients from January through November, you will net 75 percent of the year, but that's not how it works—that 75 percent data completion must be based on the entire eligibility period.

There is also the size of the list to consider. For all but the smallest ACOs, the list of denominator-eligible patients will still be too large to manually reconcile measure responses. Medicare CQMs may prevent you from having to report on potentially hundreds of thousands of patients—it can easily be tens of thousands—a far cry from the 248-patient sample of today. Without aggregating your practices' EHRs, there simply will not be enough time to search each name from CMS's denominator list, compare it to the claims file to see who recorded the most recent value, and then find and enter that value into a template that exports into a CMS-approved file type.

The bottom line: Even if reporting Medicare CQMs, your ACO will still need a plan for data collection, aggregation, and turnaround, with the [experience to help you improve](#) throughout the year.

2. Updates to Patient Attribution Methodology in ACOs Will Align More Patients with ACOs

This Proposed Rule reiterates CMS's goal that all Medicare patients will be in a model that is accountable for quality and total cost of care by 2030. According to the proposal, one of the barriers to this goal is the pre-step requirement in the ACO patient attribution methodology, and the definition of an assignable beneficiary.

Specifically, the concern is that patients who receive primary care from Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants are not being attributed to ACOs, despite the fact that they are receiving primary care from an ACO's clinicians. This issue is critical from a health equity standpoint. As these primary care delivery practices are more common in underserved communities, the current patient alignment protocols prevent—rather than promote—the delivery of equitable care.

To address this shortfall, CMS proposes adding a third step: beneficiaries who received at least one primary care service with a non-physician professional in the original 12-month window—and received a primary care service with a primary care physician in the ACO within a newly-proposed 24-month period—could be assigned to the ACO. CMS calculates that almost 3 percent of patients could be added to the total Attributable Beneficiary count, and would more accurately reflect the manner in which patients in different settings access primary care services.

3. Revised Regional Benchmarking Calculations Help ACOs Breathe Easier

Although there have been updates to benchmarking methodology intended to prevent the “ratcheting effect,” where ACOs are penalized for their own success, this Proposed Rule indicates that benchmarking is still a work in progress. To that end, a proposed update in benchmarking methodology would put a cap on the regional service area risk score between benchmark year 3 and the performance year, using an adjustment factor including the ACO’s market share.

For ACOs in areas where prospective Hierarchical Condition Category (HCC) scores are above the growth cap, this change would increase the regional component of the ACO’s update factor. Limiting risk score growth in both the ACO population and the ACO’s region is expected to provide a more accurate update factor, especially in the later years of the ACO’s agreement period. CMS anticipates that this would drive ACO participation in areas with a proportionately high number of at-risk beneficiaries, both by encouraging the formation of new ACOs, and decreasing the ACO attrition rate.

In conjunction with this Proposed Rule, CMS is offering to hold ACOs harmless in instances where the regional adjustment is negative. Those who may have received a downward adjustment are now relieved of that burden. Furthermore, those at risk of having savings payments cut via this adjustment are also exempted.

4. Additional Opportunities for Providers to Participate in MIPS Value Pathways (MVPs)—and Not Just in MIPS

[MIPS Value Pathways](#) continue their march toward an eventual “MIPS 2.0”, i.e. the end of Traditional MIPS. To bring more providers into the fold, CMS has proposed five new MVPs, centered around the following clinical areas:

Women’s Health

- Infectious Disease (focused on Hepatitis C and HIV)
- Mental Health and Substance Use Disorder
- Quality Care for Ear, Nose, and Throat
- Rehabilitative Support for Musculoskeletal Care

MVPs also make a splash in the ACO section of the Proposed Rule. Because ACOs report quality measures tied to primary care, there is an absence of quality reporting for specialists within an ACO. In order to enhance the amount of performance data coming from specialty care, CMS has floated the idea of giving ACOs bonus points for specialists reporting MVPs. They are asking for comments on how else they can illuminate the role specialists play in ACOs.

5. MIPS Cost Component: More Measures, More Visibility

Even though the Cost and Quality components of MIPS have each counted for 30 percent of the total score, the feedback on Cost has been opaque. Data made available to providers through the QPP has been limited, and nothing is available for consumers. The Proposed Rule seeks to address this by—finally—reporting cost data on [CMS's Care Compare website](#).

Unfortunately, the detail that goes into these measure calculations (risk adjustment, specialty adjustment, regional adjustment, statistical outlier corrections) creates a dilemma. With so many factors in play, how can these results be displayed in a manner that is fair to providers and informative to consumers? The answer is “we aren’t sure,” and so CMS requests feedback on how this information should be displayed.

The Cost category is also expanding, adding five new proposed measures. None of the measures target a procedure; all focus on chronic or acute conditions. If at least 20 cases are triggered, providers can expect to see scores on the following Cost measures in 2024:

- Depression
- Emergency Medicine
- Heart Failure
- Low Back Pain
- Psychoses and Related Conditions

6. Continued Challenges for Traditional MIPS Participants

Once again, the Proposed Rule tightens the belt on Traditional MIPS while incentivizing participation in MIPS Value Pathways and other Alternate Payment Models, especially Accountable Care Organizations (ACOs). Although sunseting Traditional MIPS was not proposed, there is a considerable effort to move providers into other methods of QPP participation.

As proposed, 2024 will be the most challenging year yet for Traditional MIPS participants. The performance threshold—the line between incentives and penalties—is going to increase from 75 to 82 out of 100 points. To put that in context, just a couple of years ago, 85 points put providers in the “Exceptional Performance” range, earning additional incentives. In 2024, that score barely constitutes a “pass.”

The high bar was expected. Over the last several years, PHE-related Extreme and Uncontrollable Circumstance exemptions were rubber-stamped by CMS, and many took this route in lieu of MIPS participation. Those who did report were a self-selecting group; they knew that their scores would be high enough to earn incentives, and unsurprisingly, MIPS scores were skewed. As required by statute, the performance threshold is derived from average prior period scores, and the bill is due. CMS points out that this will mean a greater payoff for those who participate, but since the program is budget-neutral, those incentives will come at someone’s expense!

As if that wasn’t enough, keeping your Quality score in a favorable range will be more challenging than before. As finalized last year, the 2024 data completion threshold—the minimum required reporting rate for MIPS CQMs to earn points—is being bumped to 75 percent through 2026. After that, the data completion threshold will be 80 percent. That’s the same level required in the PQRI (pre-PQRS!) days, wherein only three measures were required, and only Medicare Fee for Service patients were included. These proposals are in addition to the flurry of measure additions, deletions, and updates that occur each year. Some are minor, but others can be jarring. For example, several mainstay population health measures, though not topped out, are set to be retired, and replaced with a single composite measure. You may have just gone from having six measures under your belt to one measure that requires six responses!

More is at stake in 2024 MIPS than ever; the ability to avoid the program with an Extreme and Uncontrollable Circumstance exceptions will fall drastically with the end of the PHE. Increased requirements and mandatory participation will lead to higher penalties, but also the potential to

earn more meaningful incentives. To continue to succeed in MIPS, you cannot afford to let any data remain hidden, nor can your performance remain stagnant. If you have not previously considered a partner to help you through, [now may be the time](#).

7. Value-Based Care Program Alignment

If all of the individual guidelines within each program has you going in circles, you are not alone. In addition to the advancement of health equity, value-based program alignment is a theme of this Proposed Rule.

Proposals to accelerate Interoperability span across all programs. Rather than requiring a certain percentage of providers use Certified EHR Technology (CEHRT), CMS proposes that ACOs and other Alternate Payment Models require CEHRT as a condition of participation. Furthermore, ACOs and APMs will need to report the [same Promoting Interoperability measures as MIPS participants](#).

While important on its own, this change has significant implications to APP Reporting. One of the issues ACOs cited in their opposition to APP Reporting was that their membership included “paper practices”—practices that billed electronically, but who do not have an EHR from which data can be integrated—all clinical information is hand-written in paper charts. By implementing mandatory EHR use for APM participation, CMS is removing the relevance of the “paper practice” argument from the APP debate.

Both MIPS and APM participants will also need to attest to a longer performance period for these PI measure: a minimum 180 consecutive days, up from the 90-day period in effect since the start of MIPS.

As we described above, the measures in the APP are MIPS CQMs, and even with the introduction of Medicare CQMs, the same information is being measured, and the data completion threshold is the same. The MIPS/ACO line continues to blur with the possibility of ACO participants earning incentives when their specialists report specialty-specific MVPs. On a broader scale, CMS hints at a “Universal Foundation” of ten quality measures across six categories that are intended to play a role in programs beginning in 2025:

Wellness and Prevention

- Colorectal Cancer Screening
- Breast Cancer Screening
- Adult Immunization Status

Chronic Conditions

Diabetes – Hemoglobin A1c Poor Control

Hypertension – Controlling High Blood Pressure

Behavioral Health

Screening for Depression and Follow-Up Plan

Initiation and Engagement of Substance Use Disorder Treatment

Seamless Care Coordination

Planned All-cause Readmissions OR Unplanned Readmissions

Person-Centered Care

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Equity

Screening for Social Drivers of Health

As a reminder, this is a Proposed Rule, meaning that it is open to public comment. To support or critique a proposal (or lack thereof), or to respond to a question in which CMS has solicited feedback, you can visit <http://www.regulations.gov> and follow the “submit a comment” instructions, referencing CMS-1784-P.

Image: [Tim Mossholder](#)

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