CMS Presses for Accountable Care, Better Quality Measurement for Physicians and ACOs in New Proposed Rule

written by Dave Halpert | July 17, 2024

July brings us baseball, fireworks, and CMS's Proposed Rules. In 2,248 pages of proposals, CMS has outlined its plans for MIPS, ACOs, and other Advanced Alternate Payment Models, and how they will transition from fee-for-service into a value-based care arrangement through the Quality Payment Program (QPP).

We already know from the 2024 Final Rule that CMS plans to phase out Traditional MIPS in favor of MIPS Value Pathways (MVPs), and is committed to having all Traditional Medicare beneficiaries in an accountable care relationship by 2030. These Proposals continue to build on that framework, but it wouldn't be a July ballgame or a Proposed Rule without a few curve balls!

To avoid a misstep on your value-based care path, pay close attention to a few key themes in this Proposed Rule:

1. Don’t Be Lulled into Complacency by Lenient MIPS Scoring Policies

Panicking MIPS participants rejoice! Several favorable scoring updates to MIPS seem celebration-worthy, but looking down the road, it’s critical to understand the underlying reasons for these proposals. CMS intends to phase out Traditional MIPS, and while they explicitly say that they are not proposing to do so by 2029, that is the time period they have informally established. With that in mind, it’s easier to understand why there’s less push to stretch the capabilities of MIPS participants next year: they are trying to give all (potentially) 1.27 million of them just enough breathing room so that they are able to begin the shift to MVPs now, in a less risky environment.

In each instance, these scoring proposals incentivize MVP adoption—nothing is intended to bolster Traditional MIPS performance. Holding the performance threshold at 75 points is a perfect example. While the intent last year was to bring the cutoff between penalties and rewards to 82 points, many providers felt that introducing an MVP into the reporting equation would be too risky, especially since 2023 MIPS scores have only recently been released. The same principle holds for retaining the 75 percent data completion threshold for quality measures, reducing the Improvement Activity reporting burden, and maintaining the Promoting Interoperability category as is—they don’t want the transition to MVPs to occur on shaky ground.

2. MIPS Quality Category Updates Intended to Drive Specialty MVP Participation

From the 2024 Proposed and Final Rule, it was clear that CMS wanted to see MVP adoption among specialists, and was even considering bonus points for ACOs whose specialists reported MVPs, in addition to the quality reporting done through the ACO. The issue for many was that the measure development process has not kept up with CMS’s benchmarking process, resulting in instances where certain specialists had extreme limits on the measures that were available for reporting, and those that could be reported had artificial caps placed on the number of Achievement Points they could earn.

To address this, CMS has proposed a new policy for scoring measures that are “Topped Out,” the term they use to indicate that a measure’s historical performance has been so good that there is no room for improvement (and when a single failure can take you from 7 points to 1). In a departure from the draconian performance benchmarks used to score Topped Out measures today, CMS has developed a 1-10 point performance scale beginning at 84 percent, with the potential to earn all 10 points. Providers who were hamstrung from the outset will

have an opportunity earn a sustainable quality score.

This is critical for MVPs, as the MVP quality measures are plucked directly from the larger MIPS measure library. Without a policy in place to make MVPs viable for specialists with limited choices, it was more advantageous for them to remain in Traditional MIPS and report a measure that was tangential to their scope of practice. This new performance scale for Topped Out measures (and the fact that they will only need to report on 4, rather than 6) makes MVPs an attractive option.

3. A MIPS Cost Category Scoring Update Will Help, but You Need More

In MIPS, Cost is the only category in which no data is submitted; scoring is exclusively performed by CMS through an analysis of its claims. That's already a serious disadvantage for those who don't have access to comparative episodes of care modules that identify deviance from patient outcome trends and clinical standards of care, highlight notable clinical observations for review, and help you to visualize variation in cost.

The reweighting of the Cost category during the COVID-19 Public Health Emergency (PHE) and subsequent absence of Cost category feedback compounds the mystery surrounding Cost category scoring. Not surprisingly, this category had an unweighted mean of 59, compared to the next highest category (Quality), which came in at 74.

Upon examination, CMS found that small deviations on a cost measure could have a catastrophic impact on a provider's cost score. To alleviate this, they propose to modify their scoring methodology that would not disproportionately affect practices and providers who score near the median, but above the mean. This is especially important for Cost measures, as for several, a provider can be held accountable for measure with only 10 eligible cases. In a sample so small, one case can produce seismic changes in scores.

In fact, 2023 results were so curtailed by the existing scoring methodology that CMS has proposed to put the new methodology in place in the 2024 performance year. This is allowed, as the measures themselves will not actually be scored until 2025, and the payment adjustment will not come until 2026. That may seem like a reprieve; but remember, the absence of ongoing feedback still puts you at a disadvantage, and so without ongoing insights that you can use to improve throughout the year, it's only a matter of time before your scores will suffer compared to other providers', at a cost to you.

4. CMS Continues to Push ACO Development and Beneficiary Coverage

CMS believes that they are on the path to achieving their goal that all Traditional Medicare beneficiaries will be in an accountable care relationship by 2030. One of the pathways to this is ACOs. CMS cites that there were 19 newly formed ACOs in 2024, and that the 480 ACOs across the country covered 10.8 million beneficiaries. Of course, there's a long way to go before that goal is met, and so CMS has made some new proposals to entice ACO participants.

The first proposal is one that offers successful ACOs early access to their expected shared savings, referring to this as Prepaid Shared Savings. To be eligible for these payments, an ACO must be in a two-sided risk arrangement (BASIC Track C-E or ENHANCED Track), and to have consistently earned shared savings in the past, while meeting the Quality performance standard. Finally, CMS must determine that the ACO has not achieved these results by avoiding at-risk beneficiaries.

There are rules for how the prepaid shared savings may be spent—think gift cards, not cash. At least 50 percent must be spent directly on beneficiaries in a way that wouldn't otherwise be covered by Medicare. For example, meals and transportation would be allowable uses of Prepaid Shared Savings, but services covered under the fee schedule would not. The remaining funds are allowed to be spent on staffing, and on the type of infrastructure that can help you measure outcomes over time, aggregate data, and target populations for interventions. Essentially, CMS is trying to ensure that ACOs are reinvesting the savings in services that will promote value, rather than fuel expansion of the business.

The next proposal is intended to drive ACO participation in rural and underserved communities. Currently, an ACO must have at least 5,000 attributed beneficiaries to participate, and if falling short, must follow a Corrective Action Plan (CAP) to enhance attribution. Failure to reach 5,000 patients by the end of the performance period meant automatic termination. The reasoning is that, with a small sample, calculations for savings and losses are more prone to swings, as one patient has the potential to disproportionately affect the whole.

This Proposed Rule removes the automatic termination provision, leaving it to CMS's discretion. To ensure savings and losses calculations remain valid with a with a smaller sample of patients, a sliding scale based on patient volume, Minimum Sharing Rate (MSR) and Minimum Loss Rate (MLR) is applied, which differentiates statistical "signal" from "noise," and potentially keeps some ACOs in business.

To augment ACO development in rural areas, CMS has taken lessons from ACO REACH, and

proposed a Health Equity Benchmark Adjustment (HEBA). CMS claims that REACH has increased safety net provider participation, and to maintain this momentum, they created the HEBA based on dual eligibility or enrollment in Medicare Part D Low Income Subsidy (LIS). The HEBA would increase an ACO's historical benchmark, enabling them to spend more without incurring losses. Since ACOs caring for underserved populations do not typically see adjustments from regional efficiency, the HEBA is intended to both sustain existing ACOs and drive demand for new ACO formation.

Finally, CMS has proposed a series of Advanced Primary Care codes designed to recognize whole-person, integrated, and accessible care focused on health and wellness through care management relationships with patients, families, and the community, and will (if finalized) play a key role in patient attribution. These codes also effectively expand the definition of "accountable relationships," allowing a potential pathway for meeting CMS accountability of care goals and, potentially, further reimbursements. We will cover these codes and their implications in a subsequent article.

5. Seismic Shifts in ACO Quality Reporting

No, it's not the sunsetting of the CMS Web Interface after 2024—that's old news. Today's headline is that in 2025, CMS is only allowing two options for submitting APP Quality Measures: Medicare CQMs and eCQMs—the MIPS CQM option is proposed for removal. Ostensibly, this is to enable ACOs to prepare for the shift to Digital Quality Meaures (dQMs), as dQMs will use eCQMs as a base. However, the timeline for dQMs is undefined, and as we stand today, there are wide-ranging problems with eCQMs:

> Their specifications are overly complex and lack standardization.
> They are not automated; generating and processing QRDA files is extremely taxing on both human and machine IT resources.
> They do not fit into existing workflows, leading to a disproportionate number of false negatives (the response is in the record, but not in the precise field the EHR checks).
> They are not culled from multiple sources; they come from each provider's EHR alone, potentially leading to duplicates across ACO providers.

In addition to these issues is the fundamental problem with the Quality Reporting Document Architecture (QRDA) files that underpin eCQMs: they only are generated for patients who have triggered the quality measure, and only include information on that specific quality measure. In other words, they are limited to measure response values only, so that any other use besides

quality reporting is deeply restricted. In this respect, Medicare CQMs actually offer a better path to cost control than eCQMs. Insisting on QRDA-based eCQM builds doesn't break down barriers between quality reporting and patient. It builds them.

This will not always be the case (hopefully); as Fast Health Care Interoperability Resources (FHIR) APIs are developed, the building blocks of these measures may be updated to facilitate accurate quality measurement, while also enabling the exchange of data necessary for creating a strategic map for cost control. This reality has not been realized yet, however, and steering providers into a method on the cusp of change due to lack of transparency and accuracy seems ill-advised.

To make the eCQM transition more palatable, CMS is proposing additional quality points. They propose to extend the current bonus quality standard for ACOs who report the APP using eCQMs. ACOs may still meet the performance standard by achieving the 10th decile on at least one of the 4 outcome measures and the 40th decile on at least one of the remaining measures. They have also proposed "Complex Organization Adjustment" in the form of one extra achievement point for each eCQM submitted by an APM entity that met data completion and case minimum requirements.

Finally, they have proposed to retain the provision that a failure to meet this standard will not prohibit the ACO from earning shared savings. The sliding scale enabling partial shared savings could be a fixture all the way to 2028.

There is another major proposal for ACO quality reporting. In addition to the type of measures allowed in the APM Performance Pathway (APP) reporting, CMS is proposing an expansion of the APP measure set. To align quality measures across programs, CMS has adopted the Universal Foundation of Quality Measures, and this requires broad applicability. Although the three measures actively reported in the APP are applicable to many, and can be utilized to generate savings, they simply do not cover enough ground.

To address the gap between attributed patients and the number of patients included in quality measures, CMS is rolling out Phase 2 of the APP— APP Plus. The APP Plus would add 5 Adult Universal Foundation Measures incrementally from 2025 to 2028, for a total of 8 reported measures, plus the 2 CMS calculates through claims and the CAHPS survey measure. The additional measures reflect CMS's priorities in preventive care and screening (breast cancer and colorectal cancer screening, an adult immunization composite), behavioral health (Initiations and Engagement of Substance Use Disorder Treatment) and health equity (Screening for Social Drivers of Health).

6. RFIs And Solicitation of Feedback Galore: Make Your Voice Heard!

Within this Proposed Rule, there are several instances in which CMS is either formally initiating a Request for Information (RFI) or is informally soliciting feedback, including:

> Services Addressing Health Related Social Needs (HRSNs)
> Aligning FQHC/RHC Services Paid Under the PFS
> Payment for Coordinated Care Referrals Meeting Unmet HRSNs
> MVP Development, Deployment, Adoption and Performance Assessment
> Creation and Structure of a Total Risk/High-Risk ACO

These specific requests are in addition to your ability to provide feedback on any component of this Proposed Rule. To make your voice heard, visit https://www.regulations.gov/document/CMS-2024-0256-0001 before September 9, 2024 to comment.

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