In QPP, CMS raises bonus floor, floats new APM conversion factor

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Quality Payment Program

Most participants in the Quality Payment Program (QPP) won't see significant changes in reporting requirements in 2024, but CMS is cooking up big future reforms. Statutory requirements in the program's seventh year will likely result in a new payment threshold for Merit-Based Incentive Payment System (MIPS) participants and a new "qualifying APM conversion factor" method, along with other changes for Advanced APM participants.

Most MIPS reporters' 2024 requirements will be similar to those in 2023, according to the proposed Medicare physician fee schedule. The scoring percentages for the categories remain 30% for Quality performance; 30% for Cost performance; 15% for Improvement Activities (IA) performance; and 25% for Promoting Interoperability (PI) performance.

CMS proposes some adjustments to the measures to the categories: In the PI category, for example, the agency plans to "modify one of the exclusions for the Query of Prescription Drug Monitoring Program (PDMP) measure" and "provide a technical update to the ePrescribing measure's description to ensure it clearly reflects our previously finalized policy, etc." (Also, the performance period for this category would change from 90 to 180 days.)

To the Cost category, CMS proposes to add measures for Depression, Emergency Medicine, Heart Failure, Low Back Pain, and Psychoses and Related conditions, each with a 20-case minimum for reporting, and to remove the Simple Pneumonia with Hospitalization episode-based measure. They will also add five IAs, delete three and modify one.

Seven more points to make

One new number may give MIPS participants some qualms: The performance threshold MIPS reporters have to meet to avoid a penalty and qualify for a bonus is proposed to rise to 82 points from 75.

"This statutorily required increase aligns with our goal to provide practices with a greater return on their investment in MIPS participation by giving an opportunity to achieve a higher positive payment adjustment while also encouraging participation in Advanced Alternative Payment Models," the rule says.

CMS says it's confident, based on previous scores, that participants can make it: "Many clinicians have scores clustered near the proposed performance threshold of 82 points," the rule says. "For instance, 51% of clinicians have a final score between 80 and 100 points and 63.28% of clinicians have final score between 75 and 100 points."

Also, the "prior period" on which the MIPS performance threshold is based would change from one to three prior years — for 2024, for example, the 82-point threshold is based on 2017-2019 performance scores.

MVP changes

There is much talk in the rule about the program's goals going forward, in accordance to something called The Universal Foundation, described by CMS authors in a March 7, 2023, paper in the New England Journal of Medicine as "a building-block approach" that aims to "reduce provider burden by streamlining and aligning measures; advance equity with the use of measures that will help CMS recognize and track disparities in care among and within populations; aid the transition from manual reporting of quality measures to seamless, automatic digital reporting; and permit comparisons among various quality and value-based care programs, to help the agency better understand what drives quality improvement and what does not."

The main vehicle for this in MIPS seems to be the MIPS Values Pathways (MVP), an ambitious consolidation of measures across categories that remains, for the time being, voluntary (*PBN 11/14/22*). For example, CMS proposes updates "to consolidate the Promoting Wellness and Managing Chronic Conditions MVPs to align with the adult Universal Foundation measure set," and is "exploring the expansion of the APM Performance Pathway (APP) reported by clinicians in the Shared Savings Program and Advanced APMs to include the primary care universal measure set in the future."

CMS also proposes to add five new MVPs: Women's Health; Infectious Disease, Including Hepatitis C and HIV; Mental Health and Substance Use Disorder; Quality Care for Ear, Nose, and Throat (ENT); and Rehabilitative Support for Musculoskeletal Care.

Participants can wait and study the MVPs in preparation for the time, as yet unannounced by CMS, when the switch will be universal and compulsory.

CEHRT shift

CMS also announces its intention to harmonize reporting requirements for QPP with those of the Shared Savings program (*PBN 7/17/23*). For example, for participants in the non-MIPS Advanced APM program, CMS proposes to "modify the CEHRT [certified EHR technology] use criterion É to tailor CEHRT use requirements to the APM and its participants," removing the old 75%-CEHRT-use requirement, and instead requiring all providers in Advanced APMs to adopt a new, "modified, and more flexible, definition" of CEHRT. Also, qualified participants (QP) in Advanced APMs will have to fulfill the requirements of the MIPS Promoting Interoperability category.

As with the Shared Savings Program participants, it appears that if QPs meet those PI category requirements, they will fulfill their new CEHRT requirements.

This may not seem a difficult change but Paul Schmeltzer, a health care attorney with Clark Hill in Los Angeles, says federal health care agencies have noticed, as one study has found, that "there was no observable evidence that hospital APM participation was associated with interoperability engagement" and are thus planning to push them harder (*see resources, below*).

"CMS continues their push toward MIPS Promoting Interoperability requirements such that providers need to show they are using CEHRT in ways that can be measured against quality standards," Schmeltzer. explains "The proposed rules emphasize the need that health care data between practices is accurate and usable as possible, so as to not undercut the integrity of the MIPS program."

From lump sum to CF?

One proposed change that QPs in the Advanced APM program may find more troublesome is a transition from lump-sum payments to a "qualifying APM conversion factor," a 0.75% physician fee schedule update.

Previously, QPs who successfully met program requirements received a lump-sum bonus based on billings — usually 5%, though last year, thanks to a hiccup in the law, they were originally set to receive no bonus at all; Congress stepped in and gave them a 3.5% adjustment (*PBN 11/14/22*, *1/9/23)*. Non-QPs in Advanced APMs will receive a CF of 0.25%.

Also, the threshold to achieve QP status beginning in the 2024 QP Performance Period will increase from 50% of Part B payments to 75% or, for those using the Part B patient count method, from 35% to 50%. And that qualification would, under the proposed rule, have to be made at the individual level by the QPs, rather than at the APM level.

Mara McDermott, CEO of Accountable for Health, a Washington D.C.-based advocacy organization committed to accelerating the adoption of effective accountable care, thinks this will be a heavy lift for the QPs and "may result in fewer bonuses being paid out. It also creates uncertainty and the possibility that clinicians have to do both MIPS and [Advanced] APMs, because they won't know up front if they've made it, especially in the early years when the data issues get sorted out."

Industry groups aren't happy with the transition. The Medical Group Management Association (MGMA) says that while it's still reviewing the proposed rule, "MGMA is in favor of extending the APM incentive bonus. We agree with supporting group practices voluntarily transition to APMs and will be commenting on policies in the proposed rule that may hinder those efforts."

MGMA and several other industry and physician groups, including the American Academy of Family Physicians (AAFP), the American Hospital Association (AHA) and the American Medical Group Association (AMGA), sent a letter of support on July 20 to several members of Congress who are sponsoring the Value in Health Care Act of 2023, which would extend the lump sum payments.

Other changes

Among the smaller changes in the rule is a proposal to tighten the MIPS targeted review process that CMS offers participants who want official reexamination of their MIPS payment adjustment factor. Currently CMS allows requests for 60 days after the day it makes MIPS payment adjustment factors for the payment year public; this would be condensed to 30 days. Also, if CMS asks for additional information from the requestor, they have 15 days rather than 30 to provide it. CMS also proposes to allow virtual groups and subgroups to take part in the targeted review process.

As it has in the past, CMS is cracking down on qualified registries and qualified clinical data registries (QCDR) and entities that hold themselves out as such (*PBN 9/23/19*). The agency proposes to add new requirements for "third-party intermediaries" — for example, they would have to "obtain documentation of their authority to submit on behalf of a MIPS eligible clinician," "specify the use of a simplified self-nomination process" and "attest that the information contained in the qualified posting about them is correct," according to the proposed rule. CMS also proposes to toughen up its audits, corrective action and remedial action criteria on these entities.

"CMS has had some issues with certain third party intermediaries, particularly the ones that had not qualified as qualified registries or clinical qualified clinical data registries," says Dave Halpert, chief, client team of Roji Health Intelligence in Chicago. "The data they submitted had proven to be problematic. So CMS is attempting to either incentivize or penalize people based on their performance." Also, Halpert adds, "CMS has conducted audits on qualified registries and QCDRs and not everyone has performed well."

Resources

- New England Journal of Medicine, “Aligning Quality Measures across CMS — The Universal Foundation,” various CMS authors, March 7, 2023: www.nejm.org/doi/full/10.1056/NEJMp2215539
- Journal of the AMA Health Forum, “Association of Hospital Interoperable Data Sharing With Alternative Payment Model Participation,” Feb. 2022: www.ncbi.nlm.nih.gov/pmc/articles/PMC8903122/

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