CMS delays Shared Savings CEHRT and quality measure switch, but not for long

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Medicare Shared Savings Program

CMS has given participants in its premier ACO initiative, the Medicare Shared Services Program (MSSP), a year before they have to transition to a new standard for compliance with certified EHR technology (CEHRT) and mandatory digital clinical quality measures (CQM) reporting. But it appears many stakeholders are hoping for further reprieve.

CMS finalized its proposed Medicare clinical quality measures (CQM), which allow Shared Savings ACOs to perform electronic reporting on all Medicare beneficiaries, according to the final 2024 fee schedule. This will be one of three CQM methods, including electronic clinical quality measures, aka eCQM, and MIPS CQMs, from which MSSP ACOs will be required to report quality scores in 2025.

These changes "align with MIPS benchmarking and scoring policies," according to CMS, a sign of the agency's desire to harmonize the Shared Savings ACO and MIPS APM models.

The delay of the CQM changes may be a relief to many, but Dave Halpert, chief, client team of Roji Health Intelligence in Chicago, says participants who've been relying on Web Interface — the easy and popular reporting method which goes away when CQMs come in — are still not ready.

"CMS has sweetened the deal by ensuring that the total Medicare CQM denominator will be available for ACO participants — but that doesn't solve the underlying issue, which is that there are simply too many patients in the mix to successfully report using the same chart-by-chart method that works for a sample of 248 patients," which is how Web Interface works.

"Those who believe that they can transition between the Web Interface and Medicare CQMs without a substantial change to their data integration strategies are in for an unpleasant surprise," Halpert says.

Halpert isn't sure whether ACOs that have been hanging back are waiting to see whether CMS will retrench at the last minute. But he sees that "few ACOs are on track to move forward with the data-driven strategies that they will need in the future to control costs and improve outcomes."

CMS also plans to end the current Shared Savings Program CEHRT threshold requirements and harmonize them with the QPP/MIPS ones. That requirement has also been delayed until 2025.
The change should in many ways make CEHRT compliance, as well as Promoting Interoperability reporting, easier than before (*PBN 7/24/23*).

Nonetheless, Halpert says, "ACOs will need to require that all participants use CEHRT, and must prepare for the effects of non-physician clinician care on the ACO attribution model."

Formula changes

Usually rule-readers gloss over the more technical changes to MSSP, but some of the 2024 tweaks will have a meaningful impact on some ACOs' reimbursement, as well as "encourage participation by ACOs caring for medically complex, high-cost beneficiaries," as CMS states in the final rule.

For one thing, CMS is instituting a cap on risk score growth based on regional trends — a major issue for ACOs operating in sicker communities, or when there are sudden and unexplained increases in risk scores. (CMS already uses risk score caps in some models, such as ACO REACH.)

CMS also finalized plans to apply the same hierarchical condition categories (HCC) risk adjustment methodology to the benchmark and performance year for scoring purposes, change its negative regional adjustment formula to "further mitigate the impact" on "ACOs caring for medically complex, high cost beneficiaries," and make other similar recalculations to prevent the bottom from falling out from under ACOs that experience scoring drops not attributable to their quality of care.

One issue for existing MSSP ACOs, though: These adjustments are mostly for new entrants to the program, meaning that in order for a current participant to get these breaks, they'll have to renew and re-up with CMS. Contract terms are usually five years long.

Other changes

There's some tinkering with the MSSP health equity adjustment, which gives ACOs a chance at an upward quality score adjustment, provided they report CQMs, meet the data completeness requirement for each and administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey.

The multiplier on which this adjustment is based will include data on Medicare Part D low-income subsidy (LIS) enrollment or dual eligibility for Medicare and Medicaid even if the beneficiaries were only enrolled part of the year. However, beneficiaries who do not have a 2023 area deprivation index (ADI) score will be excluded from the calculation.

A new "faster" track will be added to the various tracks new MSSP participants can choose, with "a higher level of risk and potential reward than currently available under the ENHANCED track."

CMS also finalized updates to the definition of primary care services used for purposes of beneficiary assignment to include services performed by non-physician providers such as nurse practitioners and physician assistants.