

2024 Quality Payment Program Proposed Rule Summary

On Thursday, July 13, 2023, the Centers for Medicare and Medicaid Services (CMS) issued the 2024 Quality Payment Program (QPP) proposed rule that includes updates to the current program, the Merit-Based Incentive Payment System (MIPS) Value Pathways (MVP) framework, Alternative Payment Model (APM), and the APM Performance Pathway (APP).

The QPP encompasses the MIPS and the Alternative Payment Model (APM) programs, which were implemented in 2017 to replace the sustainable growth rate following the passage of the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) of 2015. It is important that radiation oncology practices understand key aspects of the QPP, which include a complex system of increasing payment bonuses and penalties under Medicare. For general information on the QPP, go to www.astro.org/qpp.

MIPS

MIPS Scoring Methodology

By law, the Cost and Quality performance categories must be equally weighted at 30% beginning in the 2022 performance period. Also, as required by law, beginning with the 2022 performance year, the performance threshold must be either the mean or median of the final scores for all MIPS eligible clinicians for a prior period. Therefore, the performance category weights remain the same for the 2023 performance period:

- Quality – 30 percent
- Improvement Activities – 15 percent
- Promoting Interoperability – 25 percent
- Cost – 30 percent

CMS is proposing to increase the performance threshold from 75 to 82 points for the 2024 performance year based on the mean scores from the 2017-2019 performance years. CMS believes that the increase, which would be applicable to all three MIPS reporting options (traditional MIPS, MVP, and the APP), aligns with the Agency's 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.

The payment adjustment for 2026 (based on 2024 performance) will range from -9% to +9%, plus any scaling to achieve budget neutrality, as required by law. Payment adjustments will be calculated based on professional services paid under the Medicare physician fee schedule (PFS), excluding Part B drugs.

Bonus Points

Complex Patients

CMS is proposing that beginning with the 2023 performance period, the complex patient bonus is limited to MIPS eligible clinicians, groups, APM Entities, and virtual groups with a risk indicator at or above the risk indicator calculated median.

Small Practice Bonus

CMS is retaining the small practice bonus of six points for the 2024 performance year to be applied to the 2026 payment year. The bonus will continue to be added to the Quality performance category. To receive the bonus, a small practice must submit Quality data. This applies to individual clinicians, group practices, virtual groups, and MIPS APM entities that consist of 15 or fewer clinicians.

Targeted Review

CMS is proposing to add subgroups and virtual groups to the list of entities that may submit a request for a targeted review for the MIPS payment adjustment factor beginning with the 2023 performance period.

Submission period

CMS is proposing to open the targeted review submission period upon release of MIPS final scores and to keep it open for 30 days after MIPS payment adjustments are released. This would maintain an approximately 60-day period for requesting a targeted review: 30 days before payment adjustments are released and 30 days after payment adjustments are released. This information must be available by October 1 so that accurate payments reflective of performance across QPP can be implemented as of January 1 of the payment year.

To date, the targeted review process has allowed CMS to review and address concerns about whether a clinician qualifies for Qualifying APM participant (QP) designation. It is essential for compiling an accurate list of QPs, which is necessary for purposes of determining who will receive the application of the higher PFS conversion factor of 0.75% beginning in the 2026 payment year.

Documentation/Information Requests

CMS is also proposing that if the Agency requests additional information under the targeted review process, that additional information must be provided to and received by CMS within 15 days of receipt of such request. This proposal would also support the Agency's ability to finalize scores and QP status by October 1.

Public Reporting

Telehealth Indicators

CMS is proposing to modify existing policy about identifying telehealth services furnished to inform the public reporting of telehealth indicators on individual clinician profile pages. Instead of using specific Place of Service (POS) and claims modifier codes such as POS code 02, 10, or modifier 95, to identify telehealth services through annual rulemaking, CMS would use the most recent POS and claims modifier codes available as of the time the information is refreshed on clinician profile pages. CMS believes this proposal would give the Agency more flexibility to ensure the accuracy of the telehealth indicator and reduce regulatory burden.

Utilization Data

CMS is proposing to modify existing policies about publicly reporting procedure utilization data on individual clinician profile pages in the following ways:

- Provide additional procedure grouping flexibility for CMS to create clinically meaningful categories when one is not available.
- Publicly reporting Medicare Advantage (MA) data, in addition to Medicare FFS utilization data counts, as appropriate and technically feasible, to address low volume counts and provide a more complete scope of a clinician's experience.
- Removing the policy to publicly report on the Provider Data Catalog (PDC), a subset of procedures from the Medicare Public Use File (PUF) and instead, providing a single downloadable dataset reflecting the same utilization data that would appear on clinician profile pages.

These proposals would address procedure category and procedure volume limitations, provide a more complete scope of a clinician's experience by adding MA data to procedure counts, align the data in the PDC with the procedural groupings shown on profile pages, and reduce redundancy with information already publicly available in the PUF.

Quality Performance Category

CMS is not proposing any changes to the data completeness threshold to 75% for the 2024 and 2025 performance periods. The Agency is proposing the following data completeness thresholds for subsequent performance periods: 75% for the 2026 performance period and 80% for the 2027 performance period.

Collection Type

Starting with the CY 2024 performance period, CMS is proposing to amend the definition of the term "collection type" to mean a set of quality measures with comparable specifications and data completeness criteria, as applicable, including, but not limited to: Electronic clinical quality measures (eCQMs); MIPS clinical quality measures (MIPS CQMs); Qualified Clinical Data Registry (QCDR) measures; Medicare Part B claims measures; CMS Web Interface measures (except as provided in paragraph (1) of this definition, for the CY 2017 through CY 2022

performance periods/2019 through 2024 MIPS payment years); the CAHPS for MIPS survey measure; administrative claims measures; and Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs). The Medicare CQMs collection type would serve as a transition collection type under the APP and be available as determined by CMS.

Data Submission Criteria for Quality Measures

CMS is proposing amendments to the data submission criteria for quality performance category to clarify that the data submission of MIPS quality measures specific to eCQMs must be submitted using certified electronic health record technology (CEHRT).

Furthermore, CMS is proposing to amend the definition of CEHRT by broadening the applicability of the health IT certification criteria that are necessary to report objectives and measures specified under MIPS (would no longer be limited to the Promoting Interoperability performance category). As a result of this proposal, the health IT certification criteria would be applicable, where necessary, for any MIPS performance category, including the criteria that support eCQMs.

CMS notes that the proposal pertaining to the data submission criteria for eCQMs requiring the utilization of CEHRT would not require third party intermediaries that report eCQMs on behalf of a MIPS eligible clinician, group, virtual group, subgroup, or APM Entity to obtain certification. Currently, third party intermediaries may facilitate reporting on behalf of a MIPS eligible clinician, group, virtual group, subgroup, or APM Entity for an eCQM while not having been certified to the certification criteria. However, if a MIPS eligible clinician, group, virtual group, subgroup, or APM Entity is relying on a third party intermediary for elements of the required certification capabilities for the MIPS eligible clinician, group, virtual group, subgroup, or APM Entity to meet the CEHRT definition applicable for their participation, then the third party intermediary would need to provide the MIPS eligible clinician, group, virtual group, subgroup, or APM Entity with a certified Health IT Module for the needed capability or capabilities.

New Measures

CMS is proposing the addition of 14 quality measures, including one composite measure and seven high priority measures, of which four are patient-reported outcome measures. CMS is also proposing the removal of 12 quality measures, and partial removal of three quality measures (removed from traditional MIPS and retained for use in MVP).

Cost Performance Category

The Agency has signaled its intent to begin publicly reporting cost measures, beginning with the 2024 performance period/2026 MIPS payment year.

CMS is proposing to add five new episode-based measures beginning with the 2024 performance period: Depression, Emergency Medicine, Heart Failure, Low Back Pain, and Psychoses and

Related Conditions. CMS is also proposing to remove the Simple Pneumonia with Hospitalization episode-based measure.

Cost Improvement Scoring

CMS is proposing to calculate improvement scoring for the cost performance category at the category level without using statistical significance beginning with the 2023 performance year. This updated methodology would ensure mathematical and operational feasibility to allow for improvement to be scored in the cost performance category starting with the 2023 performance year. This would also align with the Agency's methodology for scoring improvement in the quality performance category.

CMS is proposing that the maximum cost improvement score of one percentage point out of 100 percentage points will be available beginning with the 2023 performance period. The Agency is also proposing that the maximum cost improvement score available for the 2022 performance period will be zero percentage points.

Improvement Activities Performance Category

The Agency is proposing to add the following new improvement activities:

- Improving Practice Capacity for Human Immunodeficiency Virus (HIV) Prevention Services
- Practice-Wide Quality Improvement in MIPS Value Pathways
- Use of Decision Support to Improve Adherence to Cervical Cancer Screening and Management Guidelines
- Behavioral/Mental Health and Substance Use Screening and Referral for Pregnant and Postpartum Women
- Behavioral/Mental Health and Substance Use Screening and Referral for Older Adults

The Agency is proposing to remove the following improvement activities:

- Implementation of co-location PCP and MH services
- Obtain or Renew and Approved Waiver for Provision of Buprenorphine and Medication-Assisted Treatment (MAT) for Opioid Use Disorder
- Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging

Promoting Interoperability (PI) Performance Category

CMS is proposing to update the CEHRT definition to align with the Office of the National Coordinator for Health IT (ONC)'s regulations. In a recent proposed rule, the ONC signaled a move away from the "edition" construct for certification criteria. Instead, all certification criteria will be maintained and updated at [45 CFR 170.315](#). The Agency is proposing to align with this new definition for QPP and the Medicare Promoting Interoperability Program.

CMS is proposing to continue automatic reweighting for clinical social workers for the 2024 performance period. The Agency notes that physical therapists, occupational therapists, qualified speech-language pathologists, clinical psychologists, and registered dietitians or nutrition professionals will not be automatically reweighted beginning with the 2024 performance period.

Performance Period

CMS is proposing to increase the performance period to a minimum of 180 continuous days within the calendar year beginning with the 2024 performance period. This proposal ensures that the MIPS Promoting Interoperability performance category continues to align with the Medicare Promoting Interoperability Program for eligible hospitals and critical access hospitals.

Query of Prescription Drug Monitoring Program (PDMP) Measure Exclusion

CMS is proposing to modify this exclusion to the following: “Does not electronically prescribe any Schedule II opioids or Schedule III or IV drugs during the performance period.” CMS believes that the current exclusion is too broad and does not necessarily accommodate clinicians who do not electronically prescribe any Schedule II opioids and Schedule III and IV drugs during the performance period.

Electronic Prescribing Objective

CMS is proposing to revise the measure description to read “Number of prescriptions in the denominator generated and transmitted electronically using CEHRT” to reflect the removal of the health IT certification criterion “drug-formulary and preferred drug list checks.”

Proposed Scoring Methodology for 2024 Performance Period (Proposed changes in *italics*.)

Objective	Measure	Maximum Points	Redistribution if exclusion is claimed
Electronic Prescribing	e-Prescribing	10 points	10 points to HIE objective
	Query of PDMP	<i>10 points</i>	10 points to e-Prescribing measure
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	<i>15 points</i>	15 points to Provide Patients Electronic Access to Their Health Information measure
	Support Electronic Referral Loops by Receiving and Reconciling Health Information	<i>15 points</i>	15 points to the Support Electronic Referral Loops by Sending Health Information measure
	OR		
	HIE Bi-Directional Exchange	<i>30 points</i>	No exclusion
	OR		
	Enabling Exchange under TEFCA	30 points	No exclusion
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	25 points	No exclusion
Public Health and Clinical Data Exchange	Report the following two measures: <ul style="list-style-type: none"> • Immunization Registry Reporting • Electronic Case Reporting 	25 points	If an exclusion is claimed for both measures, 25 points are redistributed to the Provide Patients Electronic Access to their Health Information measure
	Report one of the following measures: <ul style="list-style-type: none"> • Syndromic Surveillance Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting 	5 points (bonus)	
Protect Patient Health Information	Security Risk Assessment Safety Assurance Factors for EHR Resilience Guide (SAFER Guide)	Required, but not scored.	No exclusion

MIPS Value Pathways (MVPs)

In 2021, CMS introduced the Merit Based Incentive Program Value Pathways (MVPs). MVPs are a subset of measures and activities, established through rulemaking, that can be used to meet MIPS reporting requirements beginning in the 2023 performance year. CMS established the following guiding principles associated with MVPs in the 2022 MPFS Final Rule:

- MVP must include at least one outcome measure that is relevant to the MVP topic, so MVP Participants are measured on outcomes that are meaningful to the care they provide.
- Each MVP that is applicable to more than one clinician specialty should include at least one outcome measure that is relevant to each clinician specialty included.
- In instances when outcome measures are not available, each MVP must include at least one high priority measure that is relevant to the MVP topic, so MVP Participants are measured on high priority measures that are meaningful to the care they provide.
- Allow the inclusion of outcomes-based administrative claims measures within the quality component of an MVP.
- Each MVP must include at least one high priority measure that is relevant to each clinician specialty included.
- To be included in an MVP, a qualified clinical data registry (QCDR) measure must be fully tested.

CMS developed the framework to align and connect measures and activities across the quality, cost, and improvement activities performance categories of MIPS for different specialties or conditions. In addition, the MVP framework incorporates a foundation that leverages Promoting Interoperability measures and a set of administrative claims-based quality measures that focuses on population health to reduce reporting burden.

MVPs have the following reporting criteria:

- **Quality Performance Category:** MVP Participants will select four quality measures. One must be an outcome measure (or a high-priority measure if an outcome is not available or applicable). This can include an outcome measure calculated by CMS through administrative claims, if available in the MVP.
- **Improvement Activities Performance Category:** MVP Participants will select two medium-weighted improvement activities OR one high-weighted improvement activity OR participation in a patient-centered medical home if it is already included in the MVP.
- **Promoting Interoperability Performance Category:** MVP Participants will report on the same Promoting Interoperability measures required under traditional MIPS, unless they qualify for reweighting of the Promoting Interoperability performance category.

- Cost Performance Category: MVP Participants will be scored on the cost measures included in the MVP that they select and report.
- Foundational Layer (MVP-agnostic): Population Health Measures: MVP Participants will select one population health measure to be calculated on. The results will be added to the quality score.

The Agency is proposing five new MVPs, along with revisions to all previously finalized MVPs.

The five new proposed MVPs for the 2024 performance year are:

1. Focusing on Women’s Health
2. Quality Care for the Treatment of Ear, Nose, and Throat Disorders
3. Prevention and Treatment of Infection Disorders Including Hepatitis C and HIV
4. Quality Care in Mental Health and Substance Use Disorders
5. Rehabilitative Support for Musculoskeletal Care

CMS is proposing to consolidate the previously finalized Promoting Wellness MVP and Optimizing Chronic Disease Management MVP into a single primary care MVP that aligns with the adult core set of quality measures from the [Universal Foundation](#)¹.

Facility-Based Scoring

CMS is proposing that if an MVP Participant, that is not an APM Entity or a subgroup, is eligible for facility-based scoring, a facility-based score will also be calculated.

Complex Patient Bonus for Subgroups

CMS is proposing to clarify that beginning with the 2023 performance period, subgroups would receive their affiliated group’s complex patient bonus, if available.

Performance Category Reweighting

CMS is proposing that subgroups would only receive reweighting based on any reweighting applied to its affiliated group. Under current policy, CMS is only able to review and approve a subgroup’s reweighting request after the Agency confirmed an affiliated group did not submit a reweighting request or if any reweighting was applied to the affiliated group. Therefore, a subgroup would not know of its reweighting status until later in the performance period. CMS believes this delayed review of a subgroup’s reweighting application disrupts the capability of a subgroup to determine its reweighting status and data submission needs. Further, CMS is

¹ To further the goals of the CMS National Quality Strategy, CMS leaders from across the Agency have come together to streamline quality measures across CMS quality programs for the adult and pediatric populations. This “Universal Foundation” of quality measures will focus provider attention, reduce burden, identify disparities in care, prioritize development of interoperable, digital quality measures, allow for cross- comparisons across programs, and help identify measurement gaps.

proposing that for the 2023 performance period, if reweighting is not applied to the affiliated group, the subgroup may receive reweighting in the circumstances independent of the affiliated group.

Advancing Cancer MVP

In the 2023 MPFS final rule, CMS established the Advancing Care MVP, which specifically applies to medical, hematological and gynecological oncologists.

ASTRO issued comments in response to the initial Advancing Cancer Care proposal highlighting the omission of radiation oncology. In the 2023 MPFS final rule, CMS acknowledged the concerns expressed by ASTRO, as well as others who expressed concern that the MVP was “heavily skewed towards medical oncology.”

In the 2024 MPFS proposed rule, CMS is proposing to add three additional MIPS quality measures and one QCDR measure to the Advancing Cancer MVP. According to the Agency, these measures provide a meaningful and comprehensive assessment of the clinical care for cancer patients. The last measure listed is under proposal.

- Q490: Appropriate Intervention of Immune-related Diarrhea and/or Colitis in Patients Treated with Immune Checkpoint Inhibitors
- PIMSH13: Oncology: Mutation testing for stage IV lung cancer completed prior to the start of targeted therapy
- Q487: Screening for Social Drivers of Health
- TBD: Gains in Patient Activation Measure (PAM) Scores at 12 Months

CMS is also proposing to add IA_MVP: Practice-Wide Quality Improvement in MIPS Value Pathways to the Advancing Cancer Care MVP along with the following six additional improvement activities:

- IA_BMH_12: Promoting Clinician Well-Being
- IA_CC_13: Practice Improvements to Align with OpenNotes Principles
- IA_EPA_2: Use of telehealth services that expand practice access
- IA_ERP_4: Implementation of Personal Protective Equipment (PPE) Plan
- IA_PSPA_13: Participation in Joint Commission Evaluation Initiative
- IA_PSPA_28: Completion of an Accredited Safety or Quality Improvement Program

Alternative Payment Models (APM)

Advanced APMs

Qualifying APM Participant

If an eligible clinician participates in an Advanced APM and achieves Qualifying APM Participant (QP) status, they are excluded from the MIPS reporting requirements. Eligible clinicians who achieve QP status in performance year 2023 will receive a 3.5% APM Incentive

Payment in 2025. Beginning with the 2024 performance year/2026 payment year, QPs will receive a higher MPFS payment than non-QPs due to the MACRA prescribed qualifying APM conversion factor increase of 0.75.

In the 2024 MPFS proposed rule, CMS is again modifying the Qualified Participant (QP) determination policy by proposing to eliminate the use of APM Entity-level QP determinations. This proposal comes after a decision in the 2023 MPFS final rule, in which the Agency established QP status at the individual eligible clinical level in addition to the Entity-Level. CMS added the individual eligible clinician level determination policy to address the practice of APM Entities who were removing specialists, who were frequently unable to meet QP threshold requirements, from their participation lists in an effort increase the number of eligible clinicians who are determined QPs. The 2024 MPFS proposal would eliminate this issue by removing the entity-level option.

CMS is also proposing to modify the “sixth criterion” under “attribution-eligible beneficiary,” which is used for QP determination. Currently, when calculation QP threshold scores attributed beneficiaries must meet the following criteria:

- Is not enrolled in Medicare Advantage or a Medicare cost plan
- Does not have Medicare as a secondary payer
- Is enrolled in both Medicare Parts A and B
- Is at least 18 years of age
- Is a US resident
- Has a minimum of one claim for E/M services furnished by an eligible clinician who is in an APM Entity.

In the past, CMS made exceptions to the sixth criterion to account for APMs that do not base attribution solely on E/M services such as the BPCI Models. CMS is proposing to revise the sixth criterion so that it is more in line with the shift toward eligible clinician rather than eligible entity based QP determination by modifying the criteria to recognize beneficiaries receiving any covered professional service, including E/M services.

Finally, CMS is modifying aspects of the Advanced APM program to align with the Consolidated Appropriations Act of 2023. This extends for payment years 2024 and 2025 (2022 and 2023 performance years) the payment amount threshold of 50% and the patient threshold of 35% required to achieve QP Status. The Partial QP thresholds would be set at 40% patient and 25% payment.

CEHRT Requirements

In the 2024 MPFS CMS is proposing to modify the definition of Certified Electronic Health Records Technology (CEHRT) specific to Advanced APMs. The Agency believes this will provide flexibility that allows each APM to determine what CEHRT functionalities are best suited for their APM and its participant clinicians. The proposed modification would require that the EHR technology must meet the following criterion:

1. The 2015 Edition Base EHR definition or any subsequent Base EHR definition.
2. Any such ONC Health IT certification criteria adopted or updated in 45 CFR 170.315 that are determined applicable for the APM, for the year, considering factors such as clinical practice areas involved, promotion of interoperability, relevance to reporting on applicable quality measures, clinical care delivery objectives of the APM, or any other factor relevant to documenting and communicating clinical care to patients or their health care providers in the APM.

CMS is also proposing to eliminate the 75% CEHRT use criterion for Advanced APMs, and instead specify that the APM must require all eligible clinicians to use CEHRT. According to CMS, this aligns with the proposed definition change previously discussed, which would provide greater flexibility for APMS to tailor CEHRT use requirements to the APM and its participants which makes mandatory participation possible.

Additional Resources:

CMS 2024 Quality Payment Program Proposed Rule [Resources](#)

2024 Quality Payment Program [proposed rule](#)

ASTRO [Quality Payment Program resources](#)