2024 CMS MIPS Final Rule Changes Summary

On November 2, 2023, the Centers for Medicare and Medicaid Services (CMS) released the 2024 Medicare Physician Fee Schedule (PFS) Final Rule, which includes updates to the Quality Payment Program (QPP). This summarizes the key policy changes affecting the traditional Merit-based Incentive Payment System (MIPS) program, as well as changes in reporting for Alternative Payment Models (APMs) and Accountable Care Organizations (ACOs), and expansion of MIPS Value Pathways (MVPs).

While wrapping up your 2023 MIPS reporting should be a priority, it's also important to stay informed of the upcoming changes that will impact your reporting during the 2024 performance year.

Performance Threshold Will Remain at 75 Points

CMS did not finalize the proposal to increase the performance threshold so it will remain at 75 points for the 2024 performance period (the same as the 2023 performance year). Final MIPS scores are compared to the performance threshold to calculate the MIPS payment adjustment.

The table below breaks down final MIPS scores and their associated payment adjustments based on the performance threshold.

2024 Performance Period	
CPY 2024 Final MIPS Score	**PAY 2026 Payment Adjustment**
0.0-18.75	Negative 9%
18.76-74.99	Negative MIPS payment adjustment greater than negative 9% and less than 0% on a linear sliding scale
75.0	0% adjustment
75.01-100	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 9% for scores from 75.00 to 100.00 This sliding scale is multiplied by a scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality.

Quality Performance Category Updates

Higher Data Completeness Criteria for Quality Measures

Clinicians must meet "data completeness" when reporting Quality measures to ensure that the data submitted is sufficient to assess quality performance. **CMS previously finalized a 75% data completeness threshold for the 2024 and 2025 performance periods (up from 70% in 2023) for electronic Clinical Quality Measures (eCQMs), MIPS CQMs, Medicare Part B claims**

measures, and QCDR measures. This means that Quality measures must be reported on a minimum of 75% of eligible instances for the entire year.

CMS did not finalize the proposal to increase the data completeness threshold for reporting quality measures in the 2027 performance period. The data completeness threshold will remain at 75% through the 2026 performance period.

Quality Measure Inventory Changes

There are a total of 198 quality measures for the 2024 performance period which reflect:

- 11 new Quality measures
- Removal of 11 Quality measures
- Partial removal of three measures (retained for MVP use only)
- Substantive changes to 59 existing Quality measures

CMS also finalized the addition/removal of 2 radiology measures with a one-year delay:

- A new eCQM for radiology titled Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level) **will be available for reporting during the 2025 performance year.**
- Removal of #436 Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques **for the 2025 performance period** (still available for reporting in 2024).

A list of new measures, along with their collection types, are outlined in the table below.

New Quality Measures	Collection Type
#495 Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood	MIPS CQM
#496 Cardiovascular Disease (CVD) Risk Assessment Measure - Proportion of Pregnant/Postpartum Patients that Receive CVD Risk Assessment with a Standardized Instrument	MIPS CQM
#499 Preventive Care and Wellness (composite)	MIPS CQM
#500 Connection to Community Service Provider	MIPS CQM
#501 Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy	MIPS CQM
#502 Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up	MIPS CQM
#503 Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up	MIPS CQM
#504 Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder	MIPS CQM
#505 Gains in Patient Activation Measure (PAM®) Scores at 12 Months	MIPS CQM

New Quality Measures	Collection Type
#506 Initiation, Review, And/Or Update To Suicide Safety Plan For Individuals With Suicidal Thoughts, Behavior, Or Suicide Risk	MIPS CQM
#507 Reduction in Suicidal Ideation or Behavior Symptoms	MIPS CQM

A list of measures that have been removed or partially removed is outlined in the table below.

Retired Quality Measures	Collection Type
#14 Age-Related Macular Degeneration (AMD): Dilated Macular Examination	MIPS CQM
#93 Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	MIPS CQM
#107 Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	eCQM
#110 Preventive Care and Screening: Influenza Immunization	Medicare Part B Claims, eCQM, MIPS CQM
#111 Pneumococcal Vaccination Status for Older Adults	Medicare Part B Claims, eCQM, MIPS CQM
#138 Melanoma: Coordination of Care	MIPS CQM
#147 Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	Medicare Part B Claims, MIPS CQM
#283 Dementia Associated Behavioral and Psychiatric Symptoms Screening and Management	MIPS CQM
#324 Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients	MIPS CQM
#391 Follow-Up After Hospitalization for Mental Illness (FUH)	MIPS CQM
#402 Tobacco Use and Help with Quitting Among Adolescents	MIPS CQM
Quality Measures Removed from Traditional MIPS*	**Collection Type**
#112: Breast Cancer Screening	Medicare Part B Claims, eCQM, MIPS CQM
#113: Colorectal Cancer Screening	Medicare Part B Claims, eCQM, MIPS CQM
#128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan	Medicare Part B Claims, eCQM, MIPS CQM

**These measures would still be available for MVP reporting. Quality measures 112 and 113 would also be maintained for the CMS Web Interface collection type available to Shared Savings Program ACOs reporting through the APP.*

Improvement Activities Category Updates

There are 106 Improvement Activities in the MIPS inventory for 2024, including five new activities and the removal of three existing improvement activities as outlined in the table below:

New Improvement Activities	Retired Improvement Activities
IA_PM_22 Improving Practice Capacity for Human Immunodeficiency Virus (HIV) Prevention Services Guidelines (submitted by CDC)	IA_BMH_6 Implementation of co-location PCP and MH services
IA_MVP Practice-Wide Quality Improvement in MIPS Value Pathways	IA_BMH_13 Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment [MAT] for Opioid Use Disorder
IA_PM_23 Use of Decision Support to Improve Adherence to Cervical Cancer Screening and Management	IA_ PSPA_29 Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging
IA_BMH_14 Behavioral/Mental Health and Substance Use Screening & Referral for Pregnant and Postpartum Women	
IA_BMH_15 Behavioral/Mental Health and Substance Use Screening & Referral for Older Adults	

Promoting Interoperability (PI) Category Updates

Performance Period Expanded

Beginning in 2024, the performance period for the PI Category **will increase from a minimum of 90 continuous days to a minimum of 180 continuous days within the calendar year.**

CEHRT Definition Update

The definition of Certified Electronic Health Record Technology (CEHRT) is updated to align with the Office of the National Coordinator for Health IT (ONC) regulations which move away from the "edition" construct for certification criteria. References to the "2015 Edition health IT certification criteria" will be replaced with "ONC health IT certification criteria".

PI Reweighting Changes

CMS is discontinuing automatic reweighting for the following clinician types beginning in 2024:

- Physical therapists
- Occupational therapists
- Qualified speech-language pathologists
- Clinical psychologists
- Registered dietitians or nutrition professionals

The agency plans to continue automatic reweighting for the following clinician types in the 2024 performance period:

- Clinical social workers
- ASC-based clinicians and groups
- Hospital-based clinicians and groups
- Non-patient facing clinicians and groups
- Clinicians in a small practice

PI Measure Changes

Query of Prescription Drug Monitoring Program (PDMP) Measure Exclusion - CMS has modified the current exclusion for the Query of Prescription Drug Monitoring Program (PDMP) Measure to accommodate clinicians who don't electronically prescribe any Schedule II opioids and Schedule III and IV drugs during the performance period.

Safety Assurance Factors for EHR Resilience (SAFER) Guides Measure - A **"yes" response is required to fulfill the SAFER Guide** measure beginning with the 2024 performance period.

Use of CEHRT by APMs

Currently, 75% of eligible clinicians in each participating APM Entity must be required under the terms of the APM to use CEHRT in order for the APM to be an Advanced APM. This threshold is removed under the final rule with a one-year delay. Beginning in 2025, Advanced APMs must require the use of certified EHR technology, which means EHR technology certified under the ONC Health IT Certification Program that meets the following:

(1) the 2015 Edition Base EHR definition, or any subsequent Base EHR definition; and
(2) any such ONC health IT certification criteria that are determined applicable for the APM.

Cost Category Updates

Cost Improvement Scoring

The calculation for the Cost improvement score is updated to ensure that improvement in the Cost category is more accurately scored and aligns with the Quality category scoring improvement methodology. Beginning with the 2023 performance period, the improvement scoring for the Cost category will be calculated at the category level without using statistical significance.

A maximum Cost improvement score of one percentage point out of 100 percentage points is established beginning with the 2023 performance period and a maximum Cost improvement of zero percentage points for the 2022 performance period.

Cost Measure Changes

In 2024 there will be a total of 29 Cost measures available for CMS to calculate a Cost score. Five new episode-based cost measures are added for the 2024 performance period:

- Depression (chronic condition)
- Emergency Medicine (care provided in an emergency department setting)
- Heart Failure (chronic condition)
- Low Back Pain (chronic condition)
- Psychoses and Related Conditions (acute inpatient medical condition)

The acute inpatient medical condition measure Simple Pneumonia with Hospitalization has been removed for 2024 due to coding changes.

MIPS Value Pathways (MVPs)

There are 16 MVPs available for 2024. This includes five new MVPs for the 2024 performance year:

- Focusing on Women's Health
- Quality Care for the Treatment of Ear, Nose, and Throat Disorders
- Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
- Quality Care in Mental Health and Substance Use Disorders
- Rehabilitative Support for Musculoskeletal Care.

Modifications are also made to the previously finalized MVPs*:

- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
- Advancing Cancer Care
- Advancing Care for Heart Disease

- Advancing Rheumatology Patient Care
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
- Improving Care for Lower Extremity Joint Repair
- Optimal Care for Kidney Health
- Optimal Care for Patients with Episodic Neurological Conditions
- Patient Safety and Support of Positive Experiences with Anesthesia
- Value in Primary Care
- Supportive Care for Neurodegenerative Conditions

**The Promoting Wellness MVP and the Optimizing Chronic Disease Management MVP are combined into one MVP called Value in Primary Care.*

The Final Rule clarifies that beginning with the 2023 performance period, subgroups will receive their affiliated group's complex patient bonus, if available. CMS also finalized that subgroups will only receive reweighting based on any reweighting applied to its affiliated group.

Targeted Review Timeline

CMS will open the targeted review submission period upon release of the MIPS final scores and 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.

Additionally, if CMS requests information from clinicians under the targeted review process, the information must be provided to and received by CMS within **15 days of receipt of such request**.

APM Performance Pathway (APP) Reporting Requirements

CMS Web Interface Sunsets

CMS did not make any changes to the timeline to sunset the Web Interface. The 2024 performance period will be the final performance year that the CMS Web Interface will be an available collection type for Shared Savings Program ACOs reporting quality measures under the APP. Beginning in 2025, ACOs must report either eCQMs, MIPS CQMs, and/or the new Medicare CQMs.

Medicare CQMs

CMS has created a new collection type specifically for ACOs, Medicare CQMs, which can only be reported under the APP. Medicare CQMs are intended to address the data aggregation and patient matching issues Shared Savings Program ACOs experienced when reporting eCQMs and MIPS CQMs under the APP. For the Medicare CQM collection type, an ACO that participates in the Shared Savings Program must collect and report data on only the ACO's Medicare fee-for-service beneficiaries, instead of its all-payer/all-patient population. CMS will share a list of

patients eligible for Medicare CQMs with ACOs on a quarterly basis. These lists will include encounters from specific date ranges and be updated each quarter, with the following delivery schedule:

- First quarter list: Includes encounters with dates of service from January 1st through March 31st of the performance year and is typically delivered to ACOs in May of the performance year.
- Second quarter list: Includes encounters with dates of service from January 1st through June 30th of the performance year and is typically delivered to ACOs in August of the performance year.
- Third quarter list: Includes encounters with dates of service from January 1st through September 30th of the performance year and is typically delivered to ACOs in November of the performance year.
- Fourth quarter list: Includes encounters with dates of service from January 1st through December 31st of the performance year and is typically delivered to ACOs in February of the year following the performance year. The fourth quarter list will allow ACOs to verify that they have accounted for all beneficiaries eligible for Medicare CQMs.

These changes aim to reduce ACOs' reporting burden, help them capture all eligible beneficiaries, and allow them to prepare submission data in advance. The quarterly lists will also include beneficiary-level information to assist ACOs in identifying the eligible population for each measure. However, ACOs are still responsible for evaluating their patient population against each Medicare CQM Specification to ensure data accuracy. Multiple data sources can be used to compile measure data, including EHRs, paper records, registries, and patient management systems. The quarterly lists aim to facilitate data aggregation but do not replace the need for a thorough evaluation of the criteria for each measure.

CMS expects the eventual sunsetting of the Medicare CQM collection type may be paced with the uptake of FHIR API technology, but this will be assessed based on industry readiness and CMS requirements.

Data Completeness Threshold

The 75% data completeness threshold will also apply to Medicare CQMs for the 2024-2026 performance years.

CEHRT Requirements

CMS is delaying the removal of the CEHRT threshold requirements for Shared Savings Program ACOs by one year. Beginning with the 2025 performance year, CMS will require that all MIPS eligible clinicians, Qualifying APM Participants (QPs), and Partial QPs participating in an ACO, regardless of track, must be on CEHRT. ACOs will have to satisfy all of the following requirements unless otherwise excluded:

- Report the MIPS PI performance category measures and requirements to MIPS as either of the following
    - All MIPS eligible clinicians, QPs, and partial QPs participating in the ACO as an individual, group, or virtual group; or
    - The ACO as an APM entity.
- Earn a PI performance category score at the individual, group, virtual group, or APM entity level.

Next Steps

The 2024 Final Rule makes several changes to the Quality Payment Program, including reporting under the traditional MIPS program, APM and ACO reporting, and further development of MVP reporting. TINa, physicians, and clinicians should begin reviewing these changes now so they understand the potential impact on their reporting practices for CPY 2024.