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Deep Dive
2024 Final Rule
Medicare Physician Fee Schedule and Shared Savings Program

November 2023

Housekeeping

- Type questions in the Q & A box
- This webinar will be recorded
- Links to the recording and slides will be sent to registrants
- Please complete the post-webinar survey that will appear after you close the Zoom window

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Who We Are

- 335 physician organizations
- 170,000 physicians that serve 90 million patients
- Capitation / Delegation is the destination
- “Taking Responsibility for America’s Health”

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Speakers

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Agenda

- Medicare Physician Fee Schedule (PFS)
- Medicare Shared Savings Program (MSSP)
- Quality Payment Program (QPP)

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Overview

The 2709-page PFS & MPPS final rule was released on November 2

APG's top-line summary: Focus was on **extensive changes to MSSP designed to respond to stakeholder concerns**

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Medicare Physician Fee Schedule (MPFS)

Physician Payment Update

The Conversion factor for 2024 is **$32.74**

This is a **$1.15 (or 3.4%) decrease** from the 2023 conversion factor of $33.89

CMS finalized significant **payment increases** for some **primary care** services

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New PFS codes to support primary care

- G2211 Office/Outpatient (O/O) E&M Visit Complexity Add-on Code
- G0136 Social Determinants of Health Risk Assessment + other billing options
- Community Health Integration Services (G0019, G0022)
- Principal Illness Navigation Services (G0023, G0024, G0140, G0146)
- Caregiver Training (97550, 97551, 97552)
- Caregiver Behavior Management Training (96202, 96203)

Office/Outpatient (O/O) E&M Visit Complexity Add-on Code

- CMS finalized HCPCS code G2211 to make it separately payable by assigning the “active” status indicator, effective January 1, 2024
- CMS also finalized that G2211 would not be payable when the O/O E/M visit is reported with payment modifier-25
- Use of the code depends on the longitudinal relationship between the patient and the provider

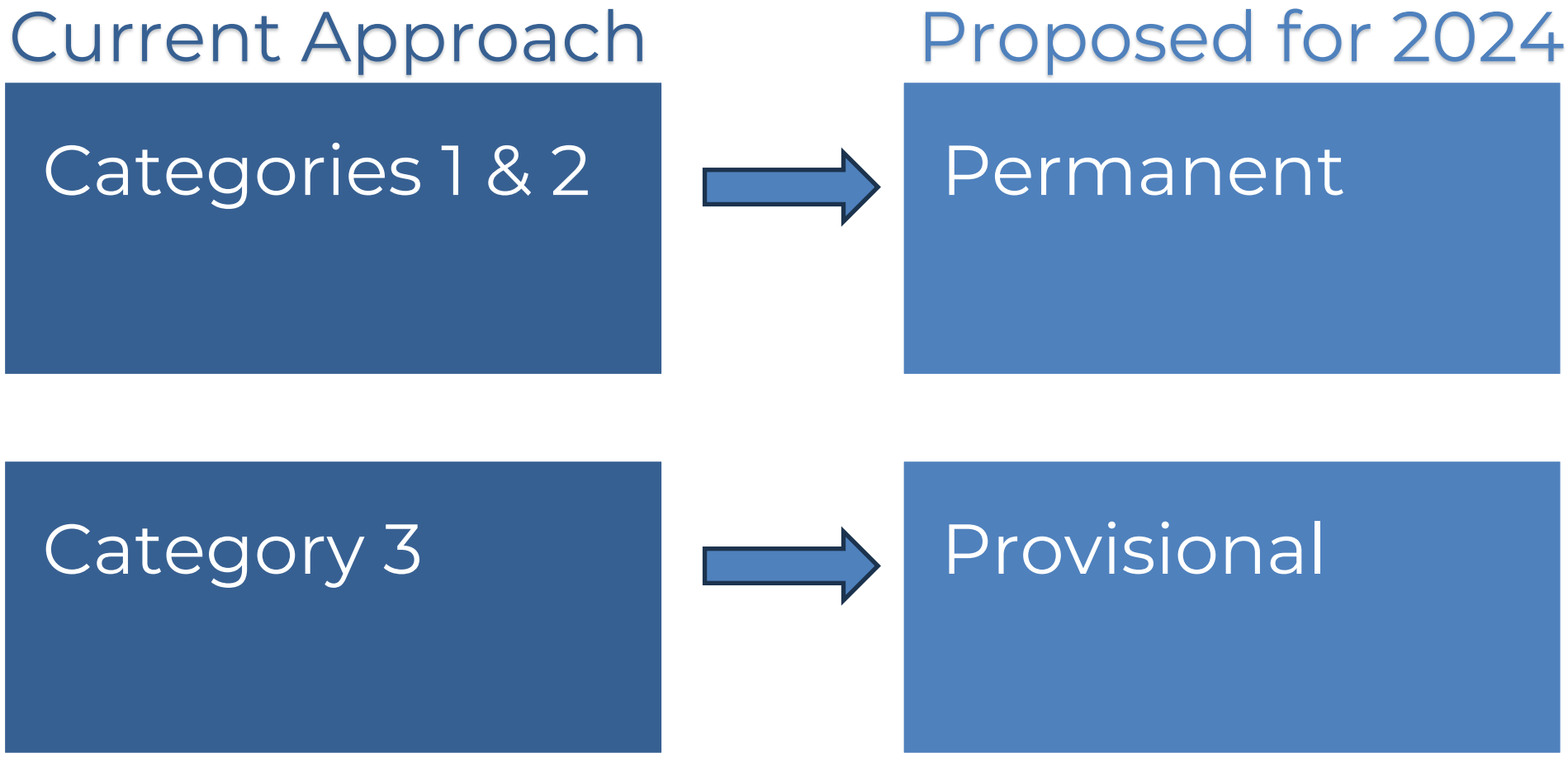
Social Determinants of Health Risk Assessment

- CMS will add a new Social Determinants of Health (SDOH) Risk Assessment as an optional, additional element of the Annual Wellness Visit (AWV) with an additional payment.
- Providers have additional options for billing, including a new stand-alone G code (G0136) for SDOH Risk Assessment furnished in conjunction with an E/M visit.

Telehealth – Implementation of CAA

- Delay required in-person visit for mental health until January 1, 2025
- Allow any originating site through December 31, 2024
- Telehealth practitioners include PTs, OTs, SLPs, and audiologists through December 31, 2024
  - CMS also proposes marriage and family therapists and mental health counselors
- Audio-only telehealth through December 31, 2024

New Telehealth Approval Process



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Billing for Telehealth

- Medicare Telehealth Services List changes for 2024:
  - Social Determinants of Health Risk Assessments added on a permanent basis.
  - Health and well-being coaching services added on a temporary basis
- CMS finalized that claims billed with POS 10 (Telehealth provided in patient's home) be paid at the non-facility PFS rate, beginning in 2024

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Billing for Telehealth

- CAA 2023 requirements finalized:
  - Expand originating site
  - Add PTs, OTs, audiologists, and SLPs to practitioners
  - Continue FQHCs & RHCs
  - Delay requirement for in-person visit within 6 months prior to mental health telehealth services
  - Continue payment for services on the Medicare Telehealth Services List until December 31, 2024

Additional Telehealth Proposals

- CMS finalized proposals to:
  - Continue to define direct supervision to permit “immediate availability” of the supervising practitioner through 2-way A/V, through December 31, 2024
  - Allow teaching physicians to have a virtual presence in all teaching settings when services are furnished virtually
  - Clarify that RPM and RTM may not be billed together and that data collection minimums of at least 16 days in a 30-day period apply

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Medicare Shared Savings Program (MSSP)

Quality and Beneficiary Assignment Changes

Summary of Final MSSP Major Quality Changes

- Report Quality Measures under APP through Medicare CQMs as a **"transition collection"**
- Revise health equity adjustment multiplier
- 40th percentile Quality performance standard is established using Historical
- Delayed Aligning ACOs CEHRT Requirements with MIPs

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Timeline of MSSP Quality Changes

2023

- Web Interface or
- eCQMs/MIPS CQM

2024

- Web Interface or
- eCQMS/MIPS CQM or
- Medicare CQM

2025

- Medicare CQM or
- eCQMs/MIPS CQM

All must include CAHPS Survey

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Medicare CQM Overview

Exclusively for ACOs FFS beneficiaries

- CMS will provider ACOs a list of beneficiaries quarterly
- CMS list may not be complete, ACO needs to ensure 100% completeness
- ACOs responsible to aggregate, match, and deduplicate
- CMS will provide guidance/specifications to ACO

Beneficiary defined as:

- meets criteria to be assigned to ACO
- one claim from during measurement period PCP, NPP (PA,NP, CNS), or specific specialties
- Beneficiary designated ACO provider

Medicare CQM

Quality Performance Standard

- Transparent Standard prior to performance year start (once historical performance is available)
- Use rolling 3 years with a 1-year lag
- Must achieve 40th percentile across all quality performance category to achieve max savings

CMS Data Completeness

- 75% for Performance Year 2024-2026
- **Did not** finalize 80% for 2027

Ultimate Goal is adoption of All payor/All patient measures

Medicare CQMs Benchmarks

- Benchmarks are specific to collection type (eCQM benchmark different from Medicare CQM)
- If collection type doesn't have historical benchmark, CMS will calculate on performance period data
- Medicare CQM won't have historical data until 2026 so will use performance period
- 20 ACOs submissions of at least 20 cases reporting data as minimum standard for establishing benchmark in performance period

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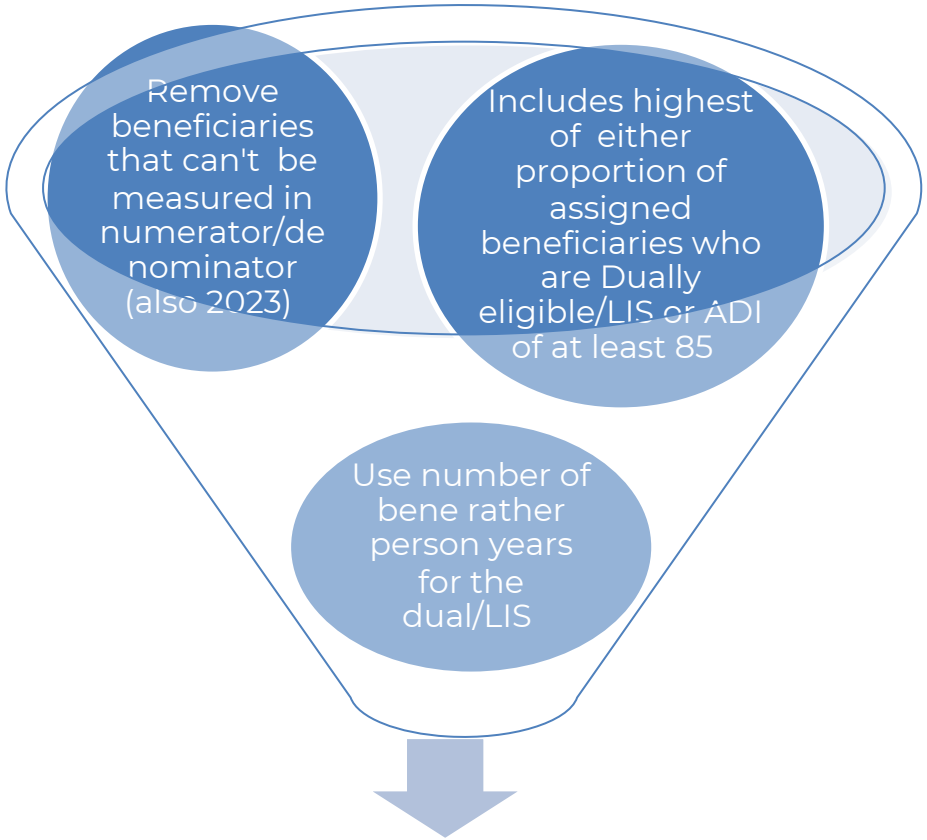
ACOs eCQMs/MIPs CQM/ Medicare CQM Quality Measures

Quality 001	Diabetes: Hemoglobin A1c	Reported/ Outcome
Quality 134	Depression Preventive and Screening	Reported/ Process
Quality 236	Controlling high pressure	Reported/ Outcome
All Cause Unplanned Readmission	Hospital Readmission	Claims/ Outcome
MCC All Cause Admission	MCC Hospital Readmission	Claims/ Outcome
CAHPS	Patient's experience	Survey

MCC-multiple chronic condition

2024 Health Equity Adjustment

Reward ACOS that serve high percent of underserved beneficiaries



A health equity adjustment (10 bonus points) on total quality

LIS- Medicare Part D low-income subsidy

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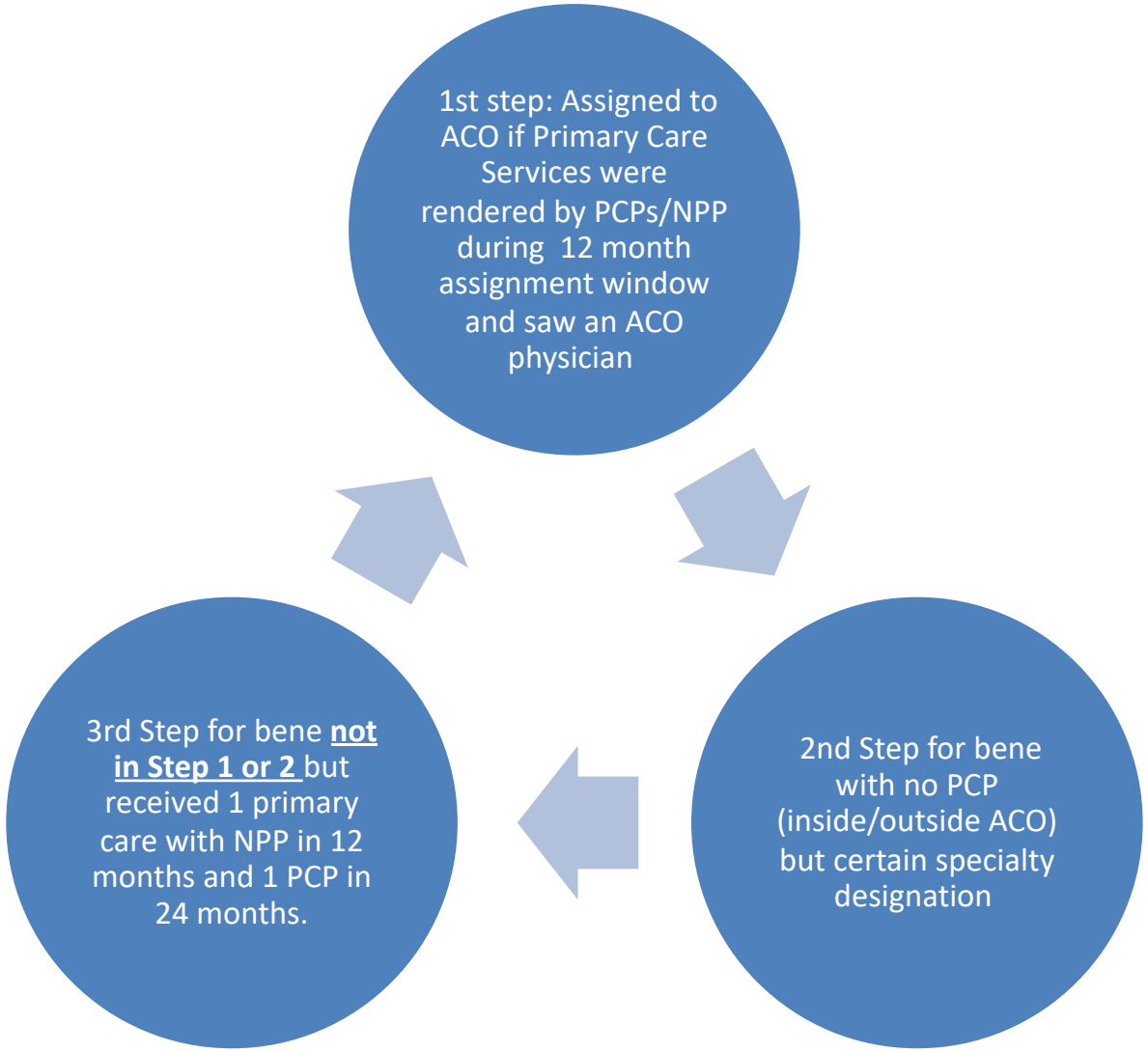
Beneficiary Assignment Methodology



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Summary of MSSP Beneficiary Assignment Changes

- Effective 2025,Add a third step-wise beneficiary assignment methodology to NPP over 12 month but need to be seen by Physician within 24 month
- Revise assignable beneficiary definition to incorporate the Step 3 changes
- Expand window for assignment to 24 months for the Step 3 in 2025
- In 2024,Added primary care codes in beneficiary assignment:

NPP- Non physician provider

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New Primary Care Codes for Assignment

Remote Patient monitoring was not approved in definition of Primary Care Codes due to prevalence of specialty billing

Smoking and tobacco use cessation counseling services	Cervical or vaginal cancer screening	Office Based opioid use disorder service
Complex evaluation and management services add on*	Community health integration*	Principal illness navigation services*
Social determinants of health risk assessment*	Caregiver behavioral management training*	Caregiver training services*

* new codes approved under Final MPFS

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Medicare Shared Savings Program (MSSP)

Risk Adjustment, Benchmarking, Advance Investment Payment Changes, and RFI

Risk Adjustment

- CMS will phase in the new V28 CMS-HCC risk model over the same multiple-year schedule applied in MA
  - For 2024: 67% current model & 33% new model
  - For 2025: 33% current model & 67% new model
  - For 2026: 100% new model
- CMS will use the same model for both benchmark and performance years **only for new agreement periods starting January 1, 2024 or later**

Benchmark Changes Finalized Last Year

- CMS made the following changes effective Jan. 1, 2024:
  - Added the Accountable Care Prospective Trend (ACPT) and made the benchmark update blend $^{1}/_{3}$ new ACPT and $^{2}/_{3}$ existing national + regional trend
  - Accounted for ACOs' prior savings in rebased benchmarks
  - Reduced the cap on negative regional adjustments from -5% to -1.5%
  - Incorporated demographic factors before applying 3% cap on ACOs' HCC risk score growth

New Finalized Benchmark Changes

- CMS adds the following for new agreements beginning in 2024:
  - Recalculate ACOs' prior savings adjustment if shared savings amounts are retroactively adjusted to account for:
    - Compliance actions to address avoidance of at-risk beneficiaries, or
    - A redetermination of shared savings or losses for previous years
  - Eliminate negative regional adjustments
  - Cap regions' risk score growth at 3%, similar to individual ACOs' HCC risk score growth.

Advance Incentive Payment (AIP)

- CMS had finalized AIPs for ACOs beginning agreement periods January 1, 2024 or later
- CMS finalized the following:
  - Allow ACOs receiving AIPs to advance in the Basic Track in Year 3
  - Allow ACOs to end an agreement and start a new Basic Track agreement without immediately repaying AIP
  - Specify that AIPs will cease if ACOs become experienced during Year 1 or 2 of become high revenue in any year
  - Terminate AIPs immediately when ACOs voluntarily terminate
  - Permit ACOs to request reconsideration of quarterly payment calculations
  - Require ACOs to report to CMS the spending plans that they must publicly report

RFI on Potential Future Changes

CMS requested stakeholder feedback on these ideas in the proposed rule and may propose policies in future rulemaking:

- Incorporating a higher risk track than the ENHANCED track
- Increasing the prior savings adjustment and modifying the positive regional adjustment to reduce the possibility of inflating the benchmark
- Refining the ACPT and 3-way blended benchmark update
- Promoting ACO and community-based organization (CBO) collaboration

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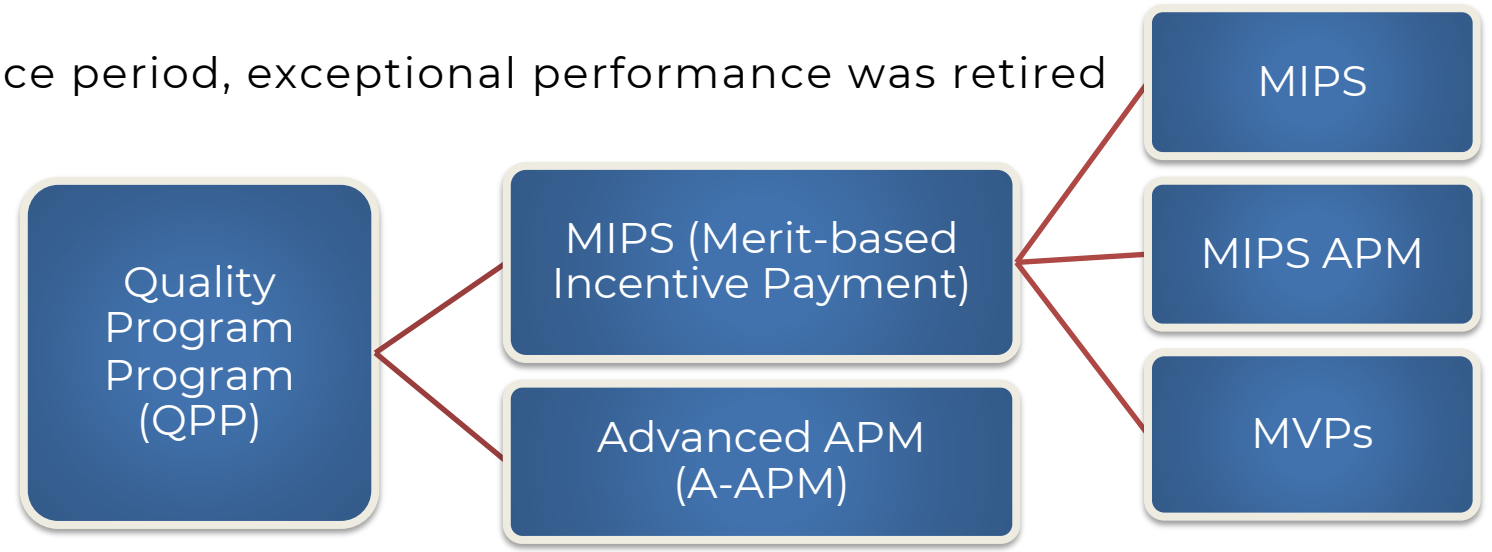
Quality Payment Program (QPP)

QPP Overview

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula for clinician payment and established the Quality Payment Program (QPP)
- 2024 is Year 8 of QPP – Year 1 (3 points), 75 in 2023, **75 remains the baseline threshold in 2024**
- Performance Year is 2 years from Payment year –
  2024 Performance Year goes with 2026 Payment Year
- In 2023 performance period, exceptional performance was retired



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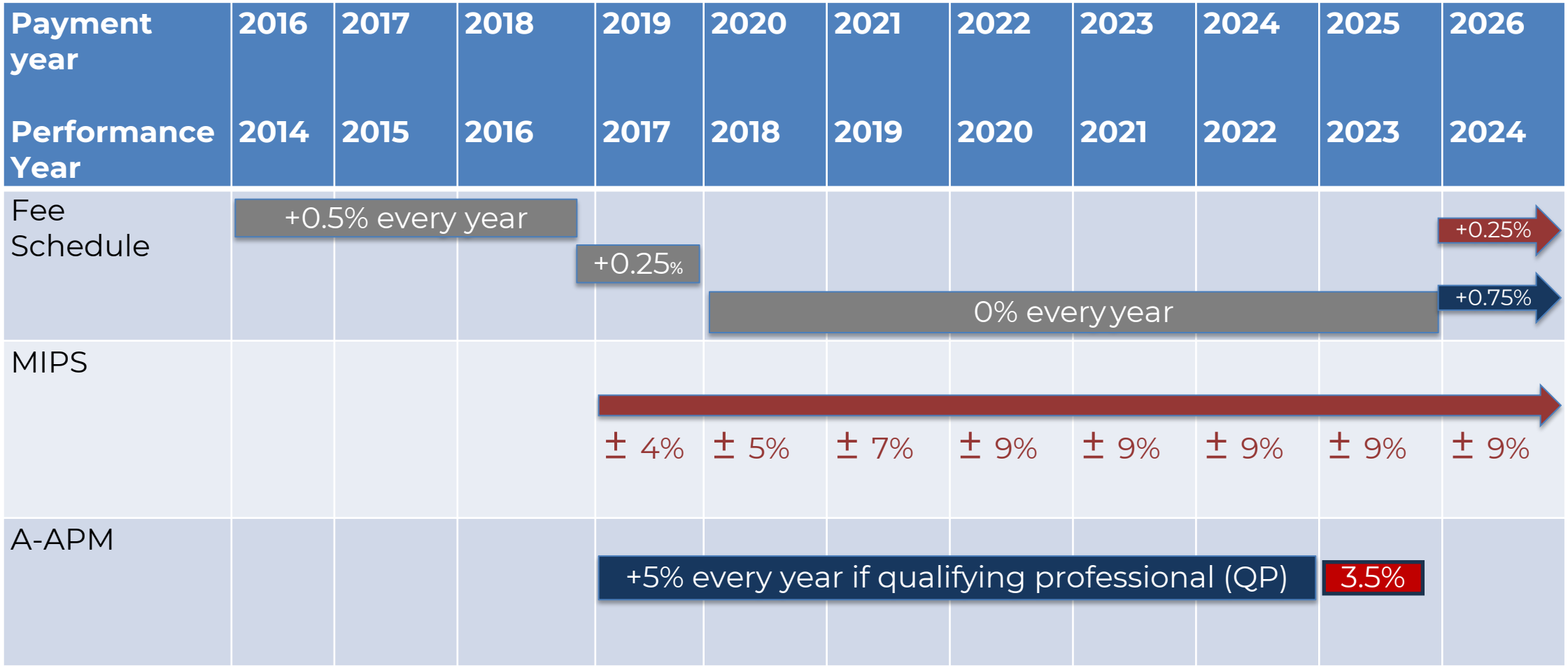
Different Payments Under MIPS and A-APMs



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MIPS Categories

Cost (30%)

- 5 new measures
- 20 episode case minimum

Quality (30%)

- Medicare CQMs
- CEHRT Requirement for submission of eCQMs
- 198 MIPs quality measures

Improvement Activities-IA (15%)

- add 5 new for a total of 106

Promoting Interoperability-PI (25%)

- Increase Performance to 180 days
- In 2025,ACOs required to report PI rather than just attesting the 75% threshold

ACO Weights	
Quality	50%
Cost	0%
IA	20%
PI	30%

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Promoting Interoperability Category

Electronic prescribing

Health Information Exchange

Provider to Patient Exchange

Public Health and Clinical Data Exchange

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APM Performance Pathway (APP)

Continue to determine QP at entity level rather than moving to individual clinician	Maintain specialists in ACO			
Align ACO CEHRT requirements with MIPS	ACOs report 50- 75% CEHRT attestation	Starting 2025, Report PI Category Measures (e-prescribing, HIE, Pt portal, Public Health)	Can be reported NPI, TIN, Virtual group or ACO	Will be weighted average if at TIN/NPI level or highest of ACO/TIN/NPI if multiple reporting
MVP	MVP is future of MIPS, moving to Universal Foundation to align with APP in 2025	Considering adding in the future up to 10 bonus points to ACOs for specialists reporting MVPs. Would allow ACOs to assess specialists' performance		

PI-promoting interoperability
MVP- MIPs Value Pathway

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Adult Universal Foundation Measures

Domain	Name
Wellness/Prevention	139 Colorectal 93 Breast Cancer Screening 26 Adult Immunization
Chronic Condition	167 Controlling BP 204 Hemoglobin A1c poor control
Behavioral	672 Depression Screening 394 Substance Use Disorder
Care Coordination	561 or 44 All Cause Readmission
Pt Centered Care	CAHPS
Equity	Screening for SDOH

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QP Threshold

Payment Year	2020	2021	2022	2023	2024	2025	2026
Perf Year	2018	2019	2020	2021	2022	2023	2024
QP Payment	25%	50%	50%	50%	50%	50%	75%
QP Pt Count	20%	35%	35%	35%	35%	35%	50%

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What to Watch For

- CMS has signaled intent to move to Universal Foundation in 2025 to unify efforts across all programs
- Sunsetting of the Medicare CQM collection type will be based on uptake of FHIR API technology
- CMS is concerned about how to better engage specialists
- Will Congress address physician pay and AAPM bonus in an end-of-year package?
- Will MSSP changes keep and attract ACOs?
- What will Congress decide to do about telehealth in 2024?

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Q&A

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