HEALTHCARE REGULATORY ROUND-UP - Episode #62

2024 Medicare Physician Fee Schedule: MIPS, MSSP, and SDOH

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Introductions

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Agenda

1. Quality Payment Program/Merit-Based Incentive Payment System
2. Medicare Shared Savings Program
3. Services Addressing Health-Related Social Needs

Quality Payment Program (QPP)
Merit-Based Incentive Payment System (MIPS)

Quality

- **Data completeness – all payers/all patients**
  - 2024 and 2025 – 75% as finalized in the 2023 MPFS
  - 2026 – finalized to hold at 75%
  - 2027 – proposal to increase to 80% **was not** finalized
  - Same thresholds apply to newly created Medicare CQMs collection type (Shared Savings Program ACOs only) but limited to Medicare FFS beneficiaries

Quality

- **198 quality measures**
  - Added 11 including:
    - 1 composite measure
    - 6 high priority measures of which 4 are patient-reported outcome measures
  - Substantive changes to 59 existing measures
  - Removal of 11 quality measures from inventory
  - Partial removal of 3 measures (112, 113, 128)
  - CAHPS for MIPS Survey - Requires use of Spanish-translation

Quality

- **Removal of 11 quality measures from inventory**
  - 014 Age-Related Macular Degeneration: Dilated Macular Examination
  - 093 Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use
  - 107 Adult Major Depressive Disorder (MDD): Suicide Risk Assessment*
  - 110 Preventative Care and Screening: Influenza Immunization*
  - 111 Pneumococcal Vaccination Status for Older Adults*
  - 138 Melanoma: Coordination of Care

* Measures 107, 110, and 111 available only for reporting via an MVP under new measure numbers

Quality

- **Removal of 11 quality measures from inventory (cont'd)**
  - 147 Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
  - 283 Dementia Associated Behavior and Psychiatric Symptoms Screening and Management
  - 324 Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients
  - 391 Follow-Up After Hospitalization for Mental Illness
  - 402 Tobacco Use and Help with Quitting Among Adolescents (duplicative to Measure 226)

Quality

- Partial removal of 3 quality measures from Traditional MIPS but retained as more robust/comprehensive measures for relevant MVP Inventory
  - 112 Breast Cancer Screening
  - 113 Colorectal Cancer Screening
  - 128 Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow Up Plan

Cost

- Maximum cost improvement score of 1 percentage point out of 100 percentage points (0 for 2022 PY)
- Improvement scoring calculated at the category level without using statistical significance (2023 PY)
- 29 cost measures - Total per Cost Capita (TPCC), Medicare Spend per Beneficiary (MSBP) Clinician, and 27 episode-based cost measures
- Added 5 new episode-based cost measures with a 20-case minimum
  - Acute inpatient medical condition (Psychoses & Related Conditions)
  - Three chronic condition measures (Depression, Heart Failure, and Low Back Pain)
  - Measure focusing on care in the Emergency Department setting
- Removed Simple Pneumonia with Hospitalization

Improvement Activities (IA)

- 106 Activities in 8 Categories
- Added 5 Activities
  - Improving Practice Capacity for HIV Prevention Services
  - Practice-Wide Quality Improvement in MIPS Value Pathways
  - Use of Computable Guidelines and Clinical Decision Support to Improve Adherence for Cervical Cancer Screening and Management Guidelines
  - Behavioral/Mental Health and Substance Use Screening & Referral for Pregnant and Postpartum Women
  - Behavioral/Mental Health and Substance Use Screening & Referral for Older Adults
- Removed 3 Activities
  - Implementation of Co-location PCP and Mental Health Services
  - Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment for Opioid Use Disorder
  - Consulting Appropriate Use Criteria Using Clinical Decision Support when Ordering

Promoting Interoperability (PI)

Discontinued automatic reweighting for:

- Physical/occupational therapists
- Qualified speech-language pathologists
- Qualified audiologists*
- Clinical psychologists
- Registered dieticians or nutrition professionals

Continuing for:

- Clinical social workers
- Ambulatory Surgical Center-based
- Hospital-based
- Non-patient facing
- Small practice

Promoting Interoperability (PI)

Performance period

- Increased to 180 days from 90 days to align with hospital/CAH requirements

Query of Prescription Drug Monitoring Program

- Modifying exclusion to “Does not electronically prescribe any Schedule II opioids or Schedule III or IV drugs during the performance period”

Safety Assurance Factors for EHR Resilience (SAFER) Guides Measure

- Requiring a “yes” answer on the attestation
- Clinicians only need to review the High Priority Practices SAFER Guide

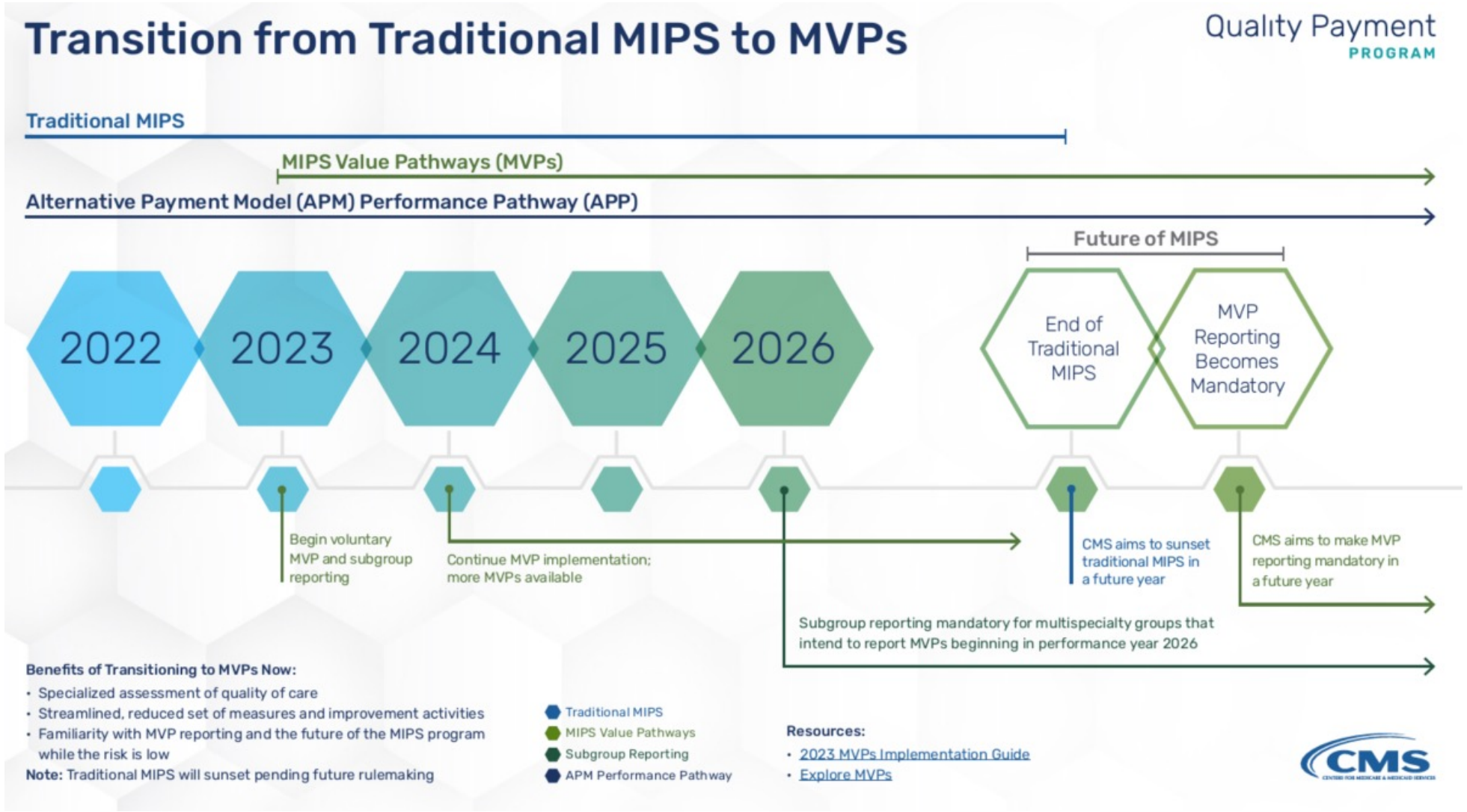
Scoring

- No change to the performance threshold – will stay at 75 for PY 2024
- CMS won't calculate a facility-based score at the sub-group level
- MVP subgroups will receive their affiliated group's complex patient bonus, if available (begins with the PY 2023)
- Performance Category Reweighting – MVP subgroups will only receive reweighting based on any reweighting applied to its affiliated group

Scoring

Your 2024 Final Score	Payment Impact for MIPS Eligible Clinicians for the 2026 MIPS Payment Year
0.00 – 18.75 points	-9% payment adjustment
18.76 – 74.99 points	Negative payment adjustment (between -9% and 0%)
75.00 points (Performance threshold=75.00 points)	Neutral payment adjustment (0%)
75.01 – 100.00 points	Positive payment adjustment (scaling factor applied to meet statutory budget neutrality requirements) As a reminder, the 2022 performance year/2024 payment year was the last year for the additional positive payment adjustment for exceptional performance.

MIPS Value Pathways (MVPs)



https://qpp.cms.gov/resources/resource-library

MVP Registration

- **Register between April 1 and December 2, 2024**
  - Must register by June 30 if using CAHPS for MIPS Survey
  - Can make changes until November 30, 2024
  - Select MVP intend to report and one population health measure included in the MVP, as well as any outcomes-based administrative claims measure on which the participant intends to be scored, if available within the MVP
  - Cannot report on an MVP that was not registered for
  - Subgroup registration
    - A list of TIN/NPIs in the subgroup
    - Plain language name for the subgroup (public reporting)
    - Description of the composition of the subgroup
    - Clinician (NPI) only allowed to register for one subgroup per TIN
    - Use the initial 12-month segment of 24-months MIPS determination period to determine eligibility

Available MVPs

Newly Finalized

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

Modified, Previously Established MVPs

- ✓ Emergency Medicine
- ✓ Advancing Cancer Care
- ✓ Heart Disease
- ✓ Rheumatology
- ✓ Stroke Care
- ✓ Lower Extremity Joint Repair
- ✓ Kidney Health
- ✓ Episodic Neurological Conditions
- ✓ Anesthesia
- ✓ Neurodegenerative Conditions
- ✓ Value in Primary Care (combination of Chronic Disease Mgmt and Promoting Wellness)

MVP Reporting Requirements

Quality Performance Category

- 4 quality measures
- 1 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

IA Performance Category

- 2 medium-weighted improvement activities OR one high-weighted improvement activity OR IA_PCMH.

Cost Performance Category

- CMS calculate performance exclusively on the cost measures that are included in the MVP using administrative claims data.

Foundational Layer

Population Health Measures

- MVP Participants must select 1 population health measure at the time of registration. CMS will calculate these measures through administrative claims and add the results to the quality score.
- For the 2024 performance period, select from:
  - Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System (MIPS) Groups
  - Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

Promoting Interoperability Performance Category

- Must submit the same Promoting Interoperability measures required under traditional MIPS, unless Participant qualifies for reweighting of the Promoting Interoperability performance category.

MVP – Promoting Interoperability

Promoting Interoperability
• Security Risk Analysis • High Priority Practices Safety Assurance Factors for EHR Resilience Guide (SAFER Guide) • e-Prescribing • Query of Prescription Drug Monitoring Program (PDMP) • Provide Patients Electronic Access to Their Health Information • Support Electronic Referral Loops By Sending Health Information AND • Support Electronic Referral Loops By Receiving and Reconciling Health Information OR • Health Information Exchange (HIE) Bi-Directional Exchange OR • Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) • Immunization Registry Reporting • Syndromic Surveillance Reporting (Optional) • Electronic Case Reporting • Public Health Registry Reporting (Optional) • Clinical Data Registry Reporting (Optional) • Actions to Limit or Restrict Compatibility or Interoperability of CEHRT • ONC Direct Review Attestation

2024 MIPS Action Items

- Evaluate available options and determine your MIPS pathway for 2024.
- Review changes to quality measures and improvement activities to evaluate the need to modify your operations, data gathering, and monitoring/reporting to facilitate success.
- Continue leveraging your operational, clinical, quality and IS team members for best opportunity for success.
- If considering MVP, ensure your vendor can support MVP data aggregation and reporting.
    - Evaluate benefits/risks of early adoption
- Continue to evaluate APM options as available and ready.
- Evaluate your entity's MIPS strategy for the next 2-3 years.

Medicare Shared Savings Program

Impact of Changes

"In total, these changes are expected to increase participation in the Shared Savings Program by roughly 10% to 20%, which will provide additional opportunities for beneficiaries to receive coordinated care from ACOs."

Quality Reporting

- Establishes Medicare Clinical Quality Measures (CQMs) as new collection type for MSSP ACOs (report solely on Medicare fee-for-service beneficiaries)
  - Diabetes: Hemoglobin A1c (HbA1c) Poor Control
  - Preventive Care and Screening: Screening for Depression and Follow-up Plan
  - Controlling High Blood Pressure
- For 2024, ACO may report quality data using CMS Web Interface measures, eCQMs, MIPS CQMs, and/or Medicare CQMs collection types
  - CMS Web Interface measures discontinued after 2024

CEHRT Requirements

- Align former MSSP CEHRT requirements with MIPS Promoting Interoperability reporting requirement to eliminate burden of complying with two separate CEHRT program requirements
  - Finalized several exclusions from reporting requirements
  - Delayed implementation of MIPS Promoting Interoperability reporting requirement until January 1, 2025

Beneficiary Assignment Methodology Modifications

- Modifications to account for beneficiaries who receive primary care from NPPs
  - Assign beneficiaries seen by NPP during applicable 12-month assignment window but only if beneficiary received at least one primary care service from physician during preceding 12 months
  - Expected to grow assignable beneficiary by more than 760,000

Benchmarking Methodology Modifications

- Apply same HCC risk adjustment model used in performance year for all benchmark years when calculating risk scores for each benchmark year
  - Applies to agreement periods beginning January 1, 2024
  - Accounts for change from Version 24 to Version 28 of CMS HCC risk adjustment model
  - Three-year phase in period (same as Medicare Advantage)
- Change calculation of regional component of 3-way blended benchmark update factor by capping risk score growth in ACO's regional service area
  - Intended to support participation by ACOs in regions with high-risk score growth by symmetrically limiting risk score growth within ACO's assigned beneficiary population and its region
- Eliminate overall negative regional adjustments
  - Intended to support participation by ACOs serving medically complex/high-cost populations

Advance Investment Payments (AIP)

- Beginning in 2024, qualifying ACOs may receive advance shared savings payments to support necessary infrastructure
- Finalized several refinements to AIP to support implementation
  - Allow ACOs to move to two-sided risk within BASIC track beginning in PY3
  - Authorize ACO receiving AIP to early renew its participation agreement after PY2 without triggering full recoupment of AIP
  - Allow CMS to immediately terminate AIPs for future quarters if ACO voluntarily terminates
  - Permit ACOs to seek reconsideration review of all quarterly AIP calculations

Services Addressing Health-Related Social Needs

CMS Health Equity Priorities

01
Expand collection, reporting, and analysis of standardized data

02
Assess causes of disparities within CMS programs and address inequities in policies and operations to close gaps

03
Build provider capacity to reduce health and healthcare disparities

04
Advance language access, health literacy, and provision of culturally tailored services

05
Increase all forms of accessibility to healthcare services and coverage

Regulatory and Payment Levers

1. CMMI Accountable Health Communities Model
2. Hospital Readmission Reduction Program – Peer Group Stratification
3. Standardized Patient Assessment Data Elements (SPADEs) for post-acute providers
4. CMMI - ACO REACH Model and Enhancing Oncology Model
5. Request for Information (RFI) - Overarching Principles for Measuring Quality Disparities Across CMS Healthcare Quality Programs
6. 2023 Hospital IPPS Final Rule
   - New Hospital IQR Measure – Hospital Commitment to Health Equity
   - New Hospital IQR Measures – Social Risk Factor Screening
7. 2024 Hospital IPPS Rule – Homelessness severity level adjustment (NonCC to CC)
8. 2023 Medicare Physician Fee Schedule Final Rule
   - Medicare Shared Savings Program
   - Quality Payment Program
9. State Medicaid program reimbursement for community health worker services

New Reimbursement for 4 Services

1. SDOH Risk Assessment – G0136
2. Community Health Integration (CHI) – G0019, G0022
3. Principal Illness Navigation (PIN) – G0023, G0024
4. PIN Peer Support – G0140, G0146

SDOH Risk Assessment - G0136

- New MPFS reimbursement for administration of standardized, evidence-based SDOH risk assessment tool, 5-15 minutes, not more often than once every 6 months
  - Does **not** have to be furnished on same day as E/M visit (but generally not performed prior to visit)
    - Not routine screening; used when practitioner has reason to believe there are unmet SDOH needs interfering with ability to diagnose and/or treat patient
    - May be furnished by auxiliary personnel if 'incident to' requirements satisfied (direct supervision)
    - Included on Medicare Telehealth Services List
  - Tools: CMS Accountable Health Communities tool, PRAPARE tool, instruments identified for MA Special Needs Population Risk Assessment
    - Identified needs must be documented in medical record; encourage use of Z-codes
- Payment rates: Non-facility - $18.67; Facility- $8.84 (+ APC 5821 - $28.29)

Community Health Integration (CHI) – G0019, G0022

- CHI Initiating Visit - E/M visit, TCM, or AWV in which billing practitioner identifies presence of SDOH need(s) that limit practitioner's ability to diagnose or treat problem(s) addressed in visit (separately billable)
  - ED, inpatient/observation, and SNF E/M visits cannot serve as CHI initiating visits
- Performed by certified or trained auxiliary personnel under general supervision of billing practitioner
  - G0019 = 60 minutes per calendar month; G0022 – each add'l 30 minutes (no frequency limitation)
  - Auxiliary personnel must be certified or trained to perform all included service elements + authorized to perform then under applicable state law/regulation
  - Service elements
    - Person-centered assessment
    - Practitioner-, home-, and community-based care coordination
    - Health education
    - Building patient self-advocacy skills
    - Health care access/health system navigation
    - Facilitating behavioral change as necessary for meeting diagnosis and treatment goals
    - Facilitating and providing social and emotional support

More CHI Details

- Auxiliary personnel must document activities (including amount of time spent) in billing practitioner's EHR
  - Include relationship to treatment plan
  - Document any identified SDOH need(s); preference for use of Z codes in EHR and claim
- Only one practitioner can bill for CHI services during given month
- Must obtain oral or written patient consent following notice of cost-sharing and that only one practitioner can bill for CHI services during given month; only required to obtain once (not annually)
- Cannot be billed when patient under home health plan of care
- Can bill in same month as care management services (no double-counting)
- Billing practitioner can arrange to have CHI services furnished through third party (e.g., CBO), provided there is sufficient clinical integration between third party and billing practitioner
- Payment rates
  - G0019 – Non-facility - $79.23; Facility - $48.78 (+ APC 5822 -$86.86)
  - G0022 – Non-facility - $49.44; Facility - $34.05 facility (no APC)

Principal Illness Navigation (PIN) - G0023, G0024

- Patients diagnosed with serious high-risk disease (e.g., cancer, COPD, dementia, severe mental illness, SUD)
  - Expected to last at least 3 months that places patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decomposition, functional decline, or death
  - Requires development, monitoring, or revision of disease-specific care plan; may require frequent adjustment in medication/treatment regimen or substantial assistance from caregiver
- PIN Initiating Visit - E/M visit, TCM, or AWV in which billing practitioner identifies medical necessity for PIN services, establishes treatment plan, and specifies how PIN services would help accomplish that plan
- Performed by certified or trained auxiliary personnel under general supervision of billing practitioner
  - G0023 = 60 minutes per calendar month; G0024 – each add'l 30 minutes (no frequency limitations)
  - Auxiliary personnel must be certified or trained to perform all included service elements + authorized to perform them under applicable state law/regulation
  - Service elements
    - Person-centered assessment
    - Practitioner-, home, and community-based care coordination
    - Health education
    - Health care access/health system navigation
    - Facilitating and providing social and emotional support
    - Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services
    - Building patient self-advocacy skills
    - Facilitating behavioral change as necessary for meeting diagnosis and treatment goals
    - Leverage knowledge of condition and/or lived experience to provide support to meet treatment goals

More PIN Details

- Same as CHI, except –
  - More than one practitioner can bill for PIN services during given month in limited circumstances
    - "[W]e do not expect a patient to require multiple PIN services for a prolonged period of time, except in circumstances in which a patient is receiving PIN services for highly specialized navigation, such as behavioral health or oncology"
  - Must obtain oral or written patient consent following notice of cost-sharing before or at initiation of PIN services ***and annually thereafter***

PIN Peer Support - G0140, G0146

- PIN services furnished by peer support specialists
  - Limited to beneficiaries with severe mental illness or SUD
  - Like PIN, except tailored scope of services consistent with peer support specialists' scope of practice
  - PIN and PIN-PS cannot be furnished concurrently for same condition
  - G0140 = 60 minutes per calendar month; G0146 – each add'l 30 minutes (no frequency limitations)
  - Same reimbursement as corresponding PIN codes

RHC Care Management Services

- G0511 - General Care Management
  - Transitional care management
  - Chronic care management
  - Principal care management
  - General behavioral health integration
  - Chronic pain management
- G0511 rate = average of national non-facility payment rate for these services
  - For 2023, $77.94 (revenue code 0521)

2024 Changes

- Additions to list of general care management services
  - Community Health Integration Services (HCPCS G0019)
  - Principal Illness Navigation Services (HCPCS G0023)
  - Remote Physiological Monitoring (CPT 99454, 99457)
  - Remote Therapeutic Monitoring (CPT 98976-77, 98980)
- May bill G0511 multiple times in calendar month, provided all requirements are met and resource costs are not counted more than once

- New calculation of G0511 payment rate

CPT Code	National Non-Facility PFS Payment Rate
99424	$81.33
99426	$61.34
99484	$43.04
99487	$133.18
99490	$62.69
99491	$85.06
G0511	**$77.94[1]**

CPT Code	2021 NF Utilization	Weighted Average
99454	931,411	46,710,262
99457	492,286	24,023,557
99457+99458	398,209	35,221,586
99474	1,581	24,110
99091	55,435	3,005,686
98976	93,141	4,671,028
98977	93,141	4,671,028
98980	14,112	698,243
98980+98981	119,463	10,647,711
99424	13,719	1,115,766
99424+99425	4,573	638,482
99426	28,858	1,770,134
99426+99427	9,619	1,046,382
99484	151,808	6,533,816
99487	26,441	3,521,412
99487+99489	229,004	46,641,245
99490	3,436,429	215,429,734
99490+99439	802,656	88,396,505
99491	29,665	2,523,322
99491+99437	118,661	17,210,562
G0511		**$72.98**

Our Next Healthcare Regulatory Round-Ups

January 24 – Coming Soon to a Statehouse Near You

February 7 – Billing Medicare for G2211: What You Need to Know Now

Resources

Resources

- Calendar Year 2024 Physician Fee Schedule Notice of Final Rule Making
- Calendar Year 2024 Medicare Physician Fee Schedule Final Rule Fact Sheet and Policy Comparison Table: Quality Payment Program Overview
- Calendar Year 2024 Newly Finalized and Modified Merit-based Incentive Payment System Value Pathways
- 2024 Medicare Physician Fee Schedule Final Rule Frequently Asked Questions for the Quality Payment Program (QPP)
- www.qpp.cms.gov
- Calendar Year 2024 Medicare Physician Fee Schedule Final Rule – Medicare Shared Savings Program Fact Sheet
- Calendar Year 2024 Medicare Physician Fee Schedule Final Rule Fact Sheet

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