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

August 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 WebEx 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

Valinda Rutledge
EVP Education and Strategic Initiatives

Jennifer Podulka
VP of Federal Policy

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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 1920-page PFS & MPPS proposed rule was released on July 13 and comments due September 11

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 **$32.75**

This is a **decrease** in the conversion factor of 3.34% from 2023 to 2024

CMS is proposing significant **payment increases** for some **primary care** services

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PFS proposals to support primary care

- Office/Outpatient (O/O) E&M Visit Complexity Add-on Code
- Social Determinants of Health Risk Assessment
- Community Health Integration Services
- Principal Illness Navigation Services
- Caregiver Training
- Caregiver Behavior Management Training

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

- CMS proposes to change the status of HCPCS code G2211 to make it separately payable by assigning the “active” status indicator, effective January 1, 2024
- CMS also proposes that G2211 would not be payable when the O/O E/M visit is reported with payment modifier-25

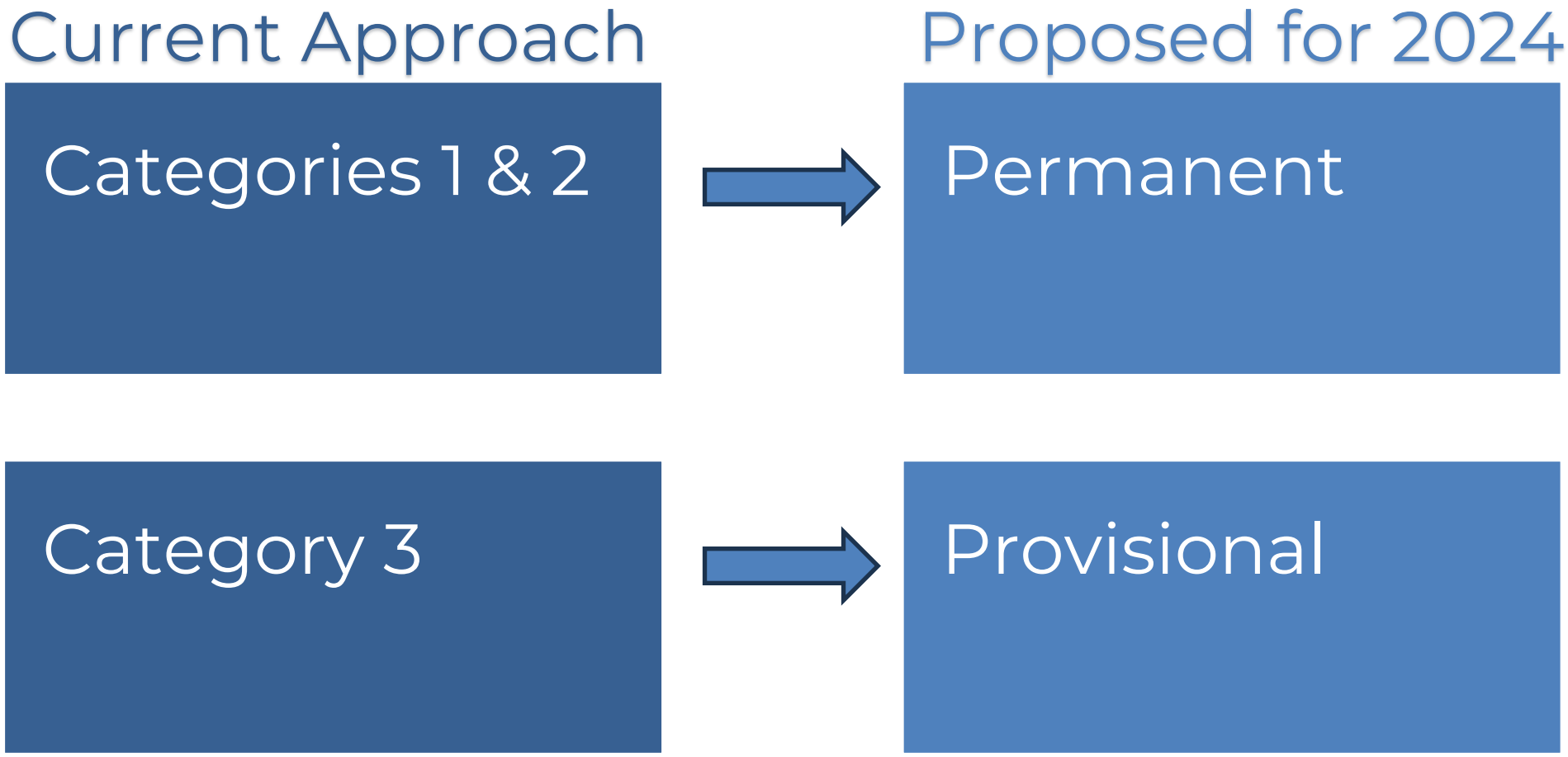
Social Determinants of Health Risk Assessment

- CMS proposes to 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.
- This proposal builds upon CMS' separate proposal to establish a stand-alone G code (GXXX5) 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

- CMS proposes that claims billed with POS 10 (Telehealth provided in patient's home) be paid at the non-facility PFS rate, beginning in 2024

Additional Telehealth Proposals

- CMS proposes 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
  - 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 MSSP Major Quality Changes

- Report Quality Measures under APP through Medicare CQMs
- Revise health equity adjustment multiplier
- 40th percentile Quality performance standard is established using Historical
- Align 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 annually
- CMS list may not be complete, ACO needs to ensure completeness
- ACOs responsible to aggregate, match, and deduplicate

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
- Use rolling 3 years with a 1-year lag
- Must meet 40th percentile across all quality performance categories to achieve full savings.

CMS Data Completeness

- 75% for Performance Year 2024-2026
- 80% for performance year 2027

ACOs eCQMs/MIPs CQM/ Medicare CQM Quality Measures

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

3 new measures proposed for 2025 as we move to universal foundation:
Adult immunization status
SUD treatment
SDOH Screening

MCC-multiple chronic condition

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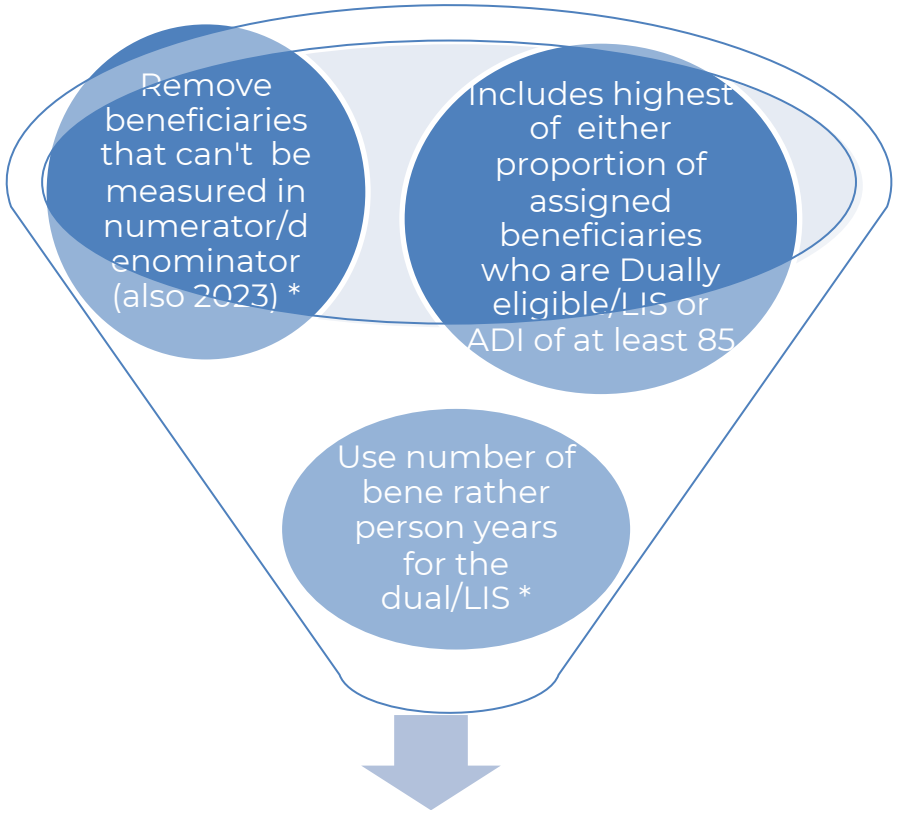
2024 Health Equity Adjustment



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

*- proposed revision

LIS- Medicare Part D low-income subsidy

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Summary of MSSP Beneficiary Assignment Changes

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

NPP- Non physician provider

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New Primary Care Codes for Assignment

- Smoking and tobacco use cessation counseling services
- Remote physiological monitoring
- 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*

*If approved under MPFS

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Medicare Shared Savings Program (MSSP)

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

Risk Adjustment

- CMS proposes to 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 also proposes to use the same model for both benchmark and performance years

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 Benchmark Proposals

- CMS proposes 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 the cap on negative regional adjustments (currently planned to be -1.5%)
  - 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 proposes 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

- 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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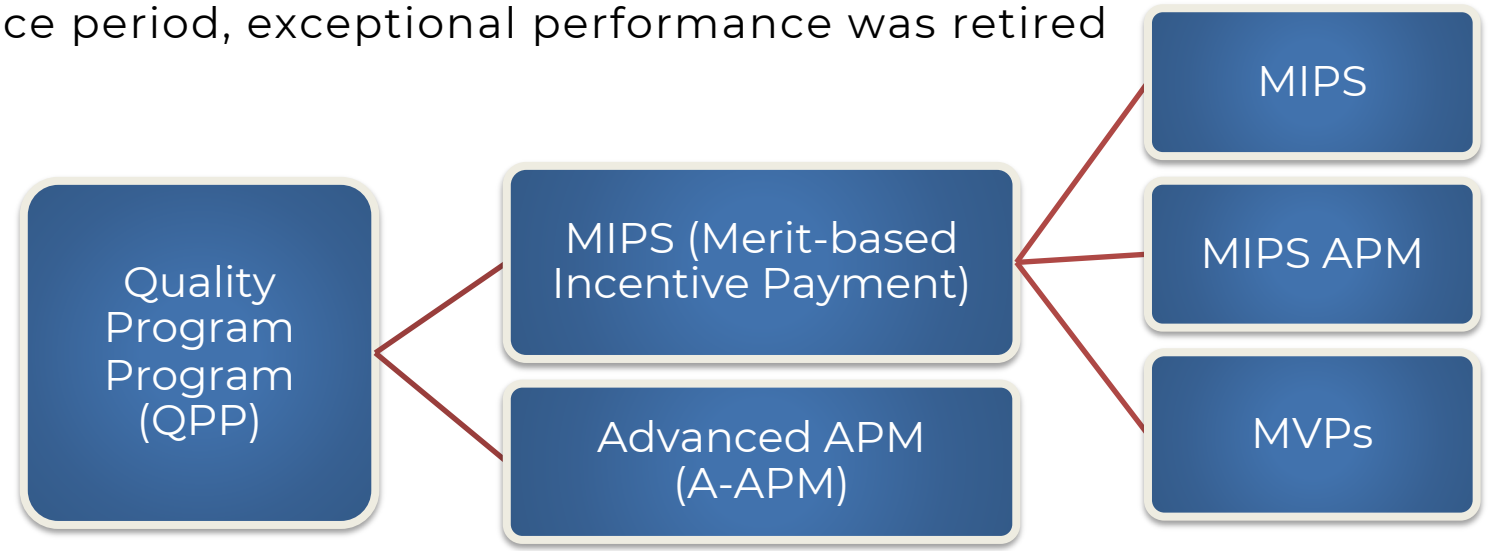
Quality Payment Program (QPP)

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, 82 is new 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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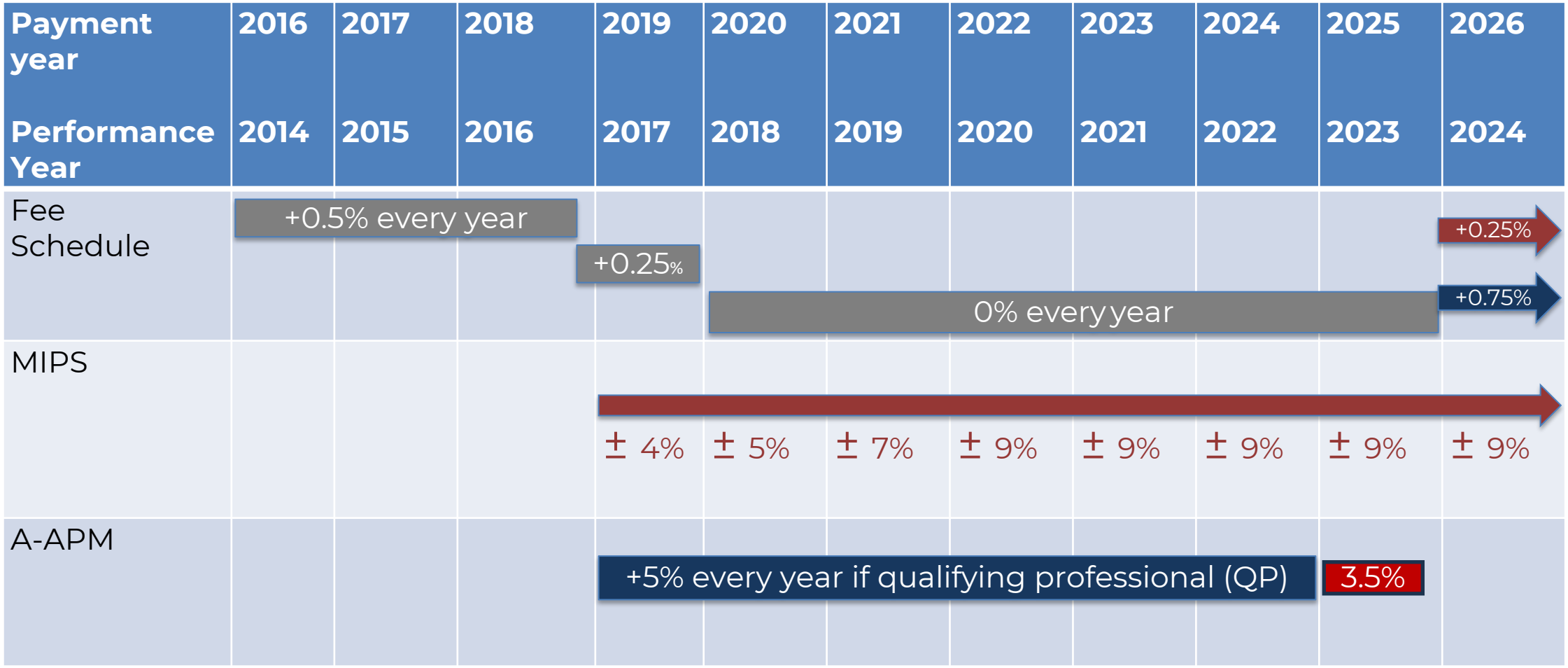
Different Payments Under MIPS and A-APMs



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MIPS Categories

Cost (30%)

- 5 new measures
- 20 episode case minimum

Quality (30%)

- Medicare CQMs
- CEHRT Requirement for eCQMs
- 200 new MIPs quality measures

Improvement Activities-IA (15%)

- add 5 new for a total of 106

Promoting Interoperability-PI (25%)

- Increase Performance to 180 days
- 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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APM Performance Pathway (APP)

Change from entity level to individual clinician	Calculate all covered professional services from NPI (not just E/M)	Remove disincentive to add specialists	
Move from 50- 75% CEHRT attestation to require all participants to report	Report PI Category Measures (e-prescribing, HIE, Pt portal, Public Health)	Can be reported NPI, TIN, or ACO	Will be weighted average if TIN/NPI level
MVP	MVP is future of MIPS, moving to Universal Foundation to align with APP in 2025	Up to 10 bonus points to ACOs for specialists reporting MVPs. Would allow ACOs to assess specialists' performance	Value in Primary Care MVP was modified

PI-promoting interoperability
MVP- MIPs Value Pathway

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Preliminary 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 *

* Potential 2025 new measures

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Value in Primary Care MVP

Quality	IA	Cost
Diabetes, BP,	Pt reported outcome, food insecurity,	Asthma/COPD
Advance Care Plan	Community Resources, Pt engagement in portal	Diabetes
Depression, Treatment of Substance Use, Statin Therapy	Pt experience, Shared Decision making,	Heart Failure
CAHPS	Exchange of pt info, timely communication of test	TPCC (total per capita Cost)

TBD: Preventive Wellness and Suicide Safety plan

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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 will be moving to Universal Foundation to unify efforts across all programs
- Will Congress extend the 3.5% Advanced APM bonus?
- Impact of moving to individual QP status rather than entity?
- Will Congress address physician pay 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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Proposed Rule Focus Groups for APG Members

Thursday, August 10th 3:00pm ET

Tuesday, August 22nd 3:00pm ET


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