Unpack the 2024 OPPS Final Rule

A WEBINAR PRESENTED ON DECEMBER 14, 2023

hcpro

Presented By

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Presented By

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Agenda

- Calendar Year (CY) 2024 Outpatient Prospective Payment System (OPPS) Final Rule Policies
  - Payment updates
  - APC and C-APC updates
  - Devices, drugs, and biologicals
    - Pass-through devices
    - 340B drug policy
    - Discarded drug policy updates
    - Comment requests
  - Inpatient-only (IPO) list
  - Supervision of cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR), and pulmonary rehabilitation (PR)
  - Dental coverage and payment issues
  - Price transparency

Agenda

- OPPS Final Rule (cont.)
  - Mental health
    - Partial Hospitalization Program (PHP)
    - Intensive Outpatient (IOP) Programs
    - MPFS mental health policies
- Significant Medicare Physician Fee Schedule (MPFS) Policies
  - Payment updates
  - Care management, including for RHC/FQHC
  - Evaluation/management update
  - Telehealth extensions
  - Enrollment updates
- Quality Updates

Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
  - Identify significant changes in the 2024 OPPS final rule
  - Discern key changes from the 2024 MPFS final rule that could affect outpatient hospital services
  - Determine the financial and operational impact of CMS' changes
  - Explain updates to quality programs and price transparency requirements

CY 2024 OPPS Final Rule

Payment Policy Updates

Finding CY 2024 OPPS Final Rule Information

- Download the rule and tables from the Hospital Outpatient Regulations and Notices page:

  https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1786-fc

  - See “2024 NFRM OPPS Facility-Specific Impacts” for payment impacts from CY 2023 to CY 2024 by individual provider
  - Also on this page:
    - Addenda
    - Revenue Code-to-Cost Center Crosswalk

CY 2024 Conversion Factor and Outlier Payment Updates

- CMS proposed a 2.8% percent increase, but finalized **3.1%**
  - Market basket percentage increase of 3.3%
  - 0.2% reduction due to the multifactor productivity adjustment
- CMS finalized a fixed-dollar threshold for outliers of $7,750 (compared to $8,625 in CY 2023)

TABLE 168: ESTIMATED IMPACT OF THE FINAL CY 2024 CHANGES FOR THE HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

	(1)	(2)	(3)	(4)	(5)
	Number of Hospitals	APC Recalibration (all changes)	New Wage Index and Provider Adjustments	All Budget Neutral Changes (combined cols 2 & 3) with Market Basket Update	All Changes
ALL PROVIDERS *	3,611	0.0	0.1	3.2	3.2
ALL HOSPITALS	3,511	0.1	0.2	3.4	3.3
(excludes hospitals held harmless and CMHCs)					
URBAN HOSPITALS	2,801	0.1	0.1	3.2	3.2
LARGE URBAN	1,452	0.0	-0.1	3.0	3.1
(GT 1 MILL.)					
OTHER URBAN	1,349	0.1	0.3	3.4	3.2
(LE 1 MILL.)					
RURAL HOSPITALS	710	0.3	1.2	4.6	4.2
SOLE COMMUNITY	373	0.1	1.5	4.8	4.3
OTHER RURAL	337	0.5	0.6	4.3	4.2

Hospital Protections

- Critical access hospitals (CAH) continue to receive cost reimbursement with the payment level set at 1% above cost or 101% of cost (before sequestration)
- Children's hospitals and cancer centers have a permanent hold-harmless protection
  - CMS applies a payment adjustment to 11 cancer centers' OPPS payments using a payment-to-cost ratio (PCR) that is equivalent to the average PCR of all other OPPS hospitals; CMS finalized a PCR for CY 2024 of 0.88
- CMS continued the 7.1% payment adjustment to OPPS services provided by rural sole community hospitals (SCH) and essential access community hospitals (EACH), excluding separately payable drugs, biologicals, and devices paid under the pass-through payment policy and items paid at cost

APC Updates

- CMS annually reconfigures and recalibrates the APC groupings, relative weights, and conversion factors based on claims data
  - CMS is using CY 2022 claims data with cost report data from CY 2021 to set CY 2024 OPPS rates – a two-year lag similar to before the PHE
    - CMS is mapping specified CAR-T-related revenue codes to clinic, hematology, IV therapy, or drug cost centers for rate setting beginning in CY 2024
- The conversion factor, after all budget neutrality adjustments, is **$87.382**
  - Slight decrease from the proposed amount of $87.488
  - The conversion factor for hospitals that failed to meet Hospital Outpatient Quality Reporting requirements is $85.687 (conversion factor x .9806)

Coinsurance Deviations

- APC coinsurance deviations
  - In the final addenda, three APCs continue to have a co-insurance higher than 20%
    - APC 5166 Cochlear Implant Procedure: 21.83% (however, due to the payment rate for the procedure, the inpatient deductible cap of $1,632 applies reducing coinsurance to ~5%)
    - APC 5191 Level 1 Endovascular Procedure: 27.64%
    - APC 5611 Level 1 Therapeutic Radiation Treatment Preparation: 23.91%
  - Addenda A and B also have a new “Note” column with coinsurances less than 20%
    - Copayments capped at the inpatient deductible of $1,632
    - Copayments capped at the inflation-adjusted coinsurance amount (drugs only)
    - Biosimilars paid at ASP plus 8% of the reference product’s ASP
      - Discussed below
  - Colorectal cancer screening tests that result in biopsy have a coinsurance set at 15% for CY 2023-2026

C-APC Updates

- CMS split two current C-APCs to **create two new C-APCs**, for a total of 72
  - Splitting C-APC 5492 (Level 2 intraocular Procedures), effectively adding new C-APC 5493 (Level 3 Intraocular Procedures) and shifting C-APCs 5493-5495 to Levels 4, 5, and 6, respectively
  - Splitting C-APC 5341 (Abdominal/Peritoneal/Biliary and Related Procedures) to C-APCs 5341 and 5342 (Level 1 and 2 Abdominal/Peritoneal/Biliary and Related Procedures, respectively)
  - Table 2 has the full list of C-APCs for CY 2024
- Continuing to exclude New Technology APCs (1491-1599 and 1901-1908) and drugs coded with C9399 from packaging in the C-APC
  - There are 46 codes assigned to new technology APCs, including two new codes with final assignments, six new codes with interim assignments, and nine codes with a change in APC

OPPS Topics With No Policy Changes

- Composite APCs
- Reporting no cost/full credit and partial credit devices
- Overall payment methodology for drug and drug administration, except as discussed below
- Clinic and emergency department visits and critical care services
- Prior authorization for outpatient surgical services

Tip: Sort Addendum B to help identify changes because CMS does not discuss all of them; specifically, use comment indicator CH to see which codes have been flagged as having a status indicator or APC (including C-APC) change

CY 2024 OPPS Final Rule

Devices, Drugs, and Biologicals

Transitional Pass-Through Payment for Devices

- Table 84 has a list of the 15 current pass-through devices with expiration dates
  - Eight are set to expire at the end of 2023, one on 6/30/24, one on 9/30/24, two on 12/31/24, and 3 on 12/31/25
- CMS **approved four applications** for device pass-through payments
  - CavaClear Inferior Vena Cava (IVC) Filter Removal Laser Sheath
    - Reported with HCPCS C1603 and procedure code 37193
  - Cerament® G – approved for IPPS New Technology Add-on Payment for FY2024
    - Reported with HCPCS C1602 and one of 30 procedure codes in Table 86
  - Ambu® aScope™ 5 Broncho HD
    - Reported with HCPCS C1601 and one of 43 procedure codes in Table 87
  - FLEX Vessel Prep™ System
    - Reported with HCPCS C1600 and procedures codes 36902, 36903, 36905, or 36906
- CMS did not approve applications for Praxis Medical CytoCore and EchoTip®

Procedure-to-Device Edits for Intraocular Procedures

- CMS is implementing a procedure-to-device edit for four procedures assigned to APC 5496 (Level 6 Intraocular Procedures)
  - Low volume APC (fewer than 100 claims)
  - Variance in devices reported: $430.72 - $15,030.04
  - Codes:
    - 0308T (Insertion of ocular telescope prosthesis) w/ C1840 (lens, intraocular [telescopic])
    - 0616T (Insertion of iris prosthesis w/o removal of lens) w/ C1839 (Iris prosthesis)
    - 0617T (Insertion of iris prosthesis w/ removal of lens) w/ C1839 (Iris prosthesis)
    - 0618T (Insertion of iris prosthesis w/ secondary lens) w/ C1839 (Iris prosthesis)

Pass-Through and Non-Pass-Through Drugs and Biologicals

- Table 89 lists the 43 drugs and biologicals with pass-through status expiring in CY 2023
- Table 90 lists the 25 drugs and biologicals with pass-through status expiring in CY 2024
  - Three on 3/31/24, 11 on 6/30/24, six on 9/30/24, and five on 12/31/24
- Table 91 lists the 59 drugs and biologicals with pass-through status expiring in CY 2025 and CY 2026
- Non-pass-through drug and biological separate payment threshold will be maintained at **$135** for CY 2024, rather than increase to $140 as proposed

Payment of Biosimilars

- Inflation Reduction Act
  - Payment limit for new biosimilars furnished on or after July 1, 2024, when ASP data is not available is the lesser of the following:
    - Not to exceed 103% of the Wholesale Acquisition Cost (WAC) or the Part B drug payment methodology in effect on November 1, 2003
    - 106% of the lesser of the WAC or ASP of the reference biological, or in the case of a selected drug during a price applicability period, 106% of the maximum fair price of the reference biological
  - Temporary payment increase for biosimilar biological products with an ASP less than the ASP of the reference biological during an applicable period
    - Payment increase: ASP plus 8% of the reference biological's ASP
    - Applicable period for biosimilar paid ASP before 9/30/22: Five-year period beginning 10/1/22
    - Applicable period for biosimilars first paid ASP 10/1/22-12/31/27: Five-year period beginning on the first day of the first quarter of ASP payment
- OPPS packaging threshold applied to a reference product is applied in the same manner to biosimilars

340B Drug Discount Policies

- In CY 2023, OPPS hospitals reported modifiers -JG and -TB for 340B-acquired drugs by all 340B-covered entities, including hospital and non-hospital entities
  - Provided CMS with data to make a required adjustment to the rebates from manufacturers of single-course drugs and biologicals with prices increasing faster than the rate of inflation
- For CY 2024, OPPS hospitals may report modifier -JG or -TB as reported in CY 2023
  - CAHs, Maryland hospitals, rural SCHs, children's hospitals, and PPS-exempt cancer hospitals still report modifier -TB
- For CY 2025, OPPS hospitals may only report modifier –TB
  - Modifier -JG will be deactivated
  - Modifier -TB (1/1/25 definition): Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes for select entities

340B Drug Payment Policy

- Policy from 2018-2022:
  - 340B-acquired drugs were paid at ASP minus 22.5%
  - In CY 2018, the savings from this provision were redistributed to all other payments under budget neutrality provisions (increasing payments for non-drug OPPS rates by 3.2%)
- In June 2022, the Supreme Court unanimously found the policy to be unlawful
  - The court found that a required survey of acquisition costs was not done to justify the variance in rates for the 340B hospitals
  - The court case related to 2018/2019 policies but is being applied to all years
  - Interestingly, CMS did a survey supporting the reduced rates (discussed in the CY 2021 OPPS final rule) but does not appear to be pursuing action to reinstate the policy
- Policy for CY 2023 and after:
  - 340B-acquired drugs are paid at ASP plus 6%

340B Drug Payment Policy

- CMS published a separate final rule (CMS-1793-F) with a repayment remedy for drugs paid at the overturned rate of ASP minus 22.5% for CY 2018-2022
  - $9 billion owed to 1,700 affected hospitals
    - One lump sum payment (amount published in Addendum AAA)
    - No beneficiary copayments will apply
  - $7.8 billion in additional non-drug payments that need to be recouped
    - Finalized a 0.5% adjustment to the OPPS conversion factor starting in CY 2026 (originally proposed for CY 2025) and ending when $7.769 billion has been recouped
      - CMS estimates this adjustment will take approximately 16 years
    - Exception from reduction for ~300 new providers enrolled after January 1, 2018 (list published in Addendum BBB)
      - This would result in two conversion factors, but it is unclear how this will be implemented

Single-Use Package Reporting (Modifiers -JW/-JZ)

- Applies to “single-dose container or single-use package drugs”
  - “Single-dose container or single-use package based on FDA approved labeling”
    - FDA labeling “typically” includes an instruction to discard unused portions
    - Includes drugs labeled as part of a kit that is intended for single dose or single use
  - All single-dose containers separately payable under Part B require –JW/-JZ
    - Reporting is not limited to drugs subject to the refund requirement
- Modifier implementation
  - -JW required January 1, 2023 (previously implemented through sub-regulatory guidance in 2017)
  - -JZ effective January 1, 2023, required July 1, 2023
  - -JW/-JZ not used between July 1, 2023, and September 30, 2023, subject to provider audits
  - -JW/-JZ editing October 1, 2023 (returned as un-processable, rejection?)
    - CMS states to hold claims if not ready to report correctly by 10/1/23

Single-Use Package Reporting (Modifiers -JW/-JZ)

- In October, CMS published a list of drugs that require the -JZ/-JW modifiers (https://www.cms.gov/files/document/jw-modifier-and-jz-modifier-policy-hcpcs-codes.pdf)
  - The list is not all-inclusive
- Applicability to specific providers
  - HOPD: Applies to drugs with status indicator G or K
    - Does not apply to drugs that are not separately payable under Part B (i.e., status indicator N for HOPD and N1 for ASCs)
    - Not clear how this applies to CAHs – all drugs are separately payable
  - ESRD: Applies to non-renal dialysis drugs reported with modifier -AY
  - Suppliers: Drugs furnished under Part B but not administered by the provider, the provider should append modifier -JZ to ensure edits aren't applied inappropriately
  - Modifiers do not apply in rural health clinic (RHC)/federally qualified health center (FQHC) setting

Single-Use Package Reporting (Modifiers -JW/-JZ)

- Documenting and calculating wastage
  - Wastage should be documented in the patient's medical record
    - No documentation is needed if no wastage is reported with -JZ modifier
    - CMS states general documentation instructions are in SE1316, but they are no longer posted
  - Calculate the discarded amount by subtracting the dose administered from the labeled amount on the vial
    - Dose is the administered amount
    - Don't count overfill
  - Calculated on the actual purchased vial size and not the smallest vial for purchase
    - Prior guidance in SE1316 had stated to bill only the smallest available vial
      - CMS states this was superseded by MM9603 (but they also state to use SE1316 for general documentation guidance)

Devices, Drugs, and Biologicals – Comment Requests

- Non-opioid treatments for pain relief
  - CAA of 2023 mandates separate/additional payment during CY 2025-2028
  - CMS provided an overview of comments
- Diagnostic radiopharmaceuticals
  - Expensive new radiopharmaceuticals are policy-packaged after the pass-through status expires
  - There may be barriers to beneficiary access to advanced tests using new radiopharmaceuticals
  - CMS reviewed the comments and potential payment methods but took no action in the rule
- Self-administered drugs and non-chemo complex drug infusions
  - MPFS RFI on definitions and policies
    - CMS reviewed comments but took no action

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Inpatient-Only Procedures and Nonrecurring Policy Changes

IPO List Updates

- Table 103 lists the **nine** newly created CPT codes added to the inpatient-only (IPO) list
- One code was reassigned from E1 to the IPO list

0790T	Revision (e.g., augmentation, division of tether), replacement, or removal of thoracolumbar or lumbar vertebral body tethering, including thoracoscopy, when performed	Add to the IPO list	C
22836	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; up to 7 vertebral segments	Add to the IPO list	C
22837	Anterior thoracic vertebral body tethering, including thoracoscopy, when performed; 8 or more vertebral segments	Add to the IPO list	C
22838	Revision (e.g., augmentation, division of tether), replacement, or removal of thoracic vertebral body tethering, including thoracoscopy, when performed	Add to the IPO list	C
61889	Insertion of skull-mounted cranial neurostimulator pulse generator or receiver, including craniectomy or craniotomy, when performed, with direct or inductive coupling, with connection to depth and/or cortical strip electrode array(s)	Add to the IPO list	C
76984	Ultrasound, intraoperative thoracic aorta (e.g., epiaortic), diagnostic	Add to the IPO list	C
76987	Intraoperative epicardial cardiac (e.g., echocardiography) ultrasound for congenital heart disease, diagnostic; including placement and manipulation of transducer, image acquisition, interpretation and report	Add to the IPO list	C
76988	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; placement, manipulation of transducer, and image acquisition only	Add to the IPO list	C
76989	Intraoperative epicardial cardiac ultrasound (ie, echocardiography) for congenital heart disease, diagnostic; interpretation and report only	Add to the IPO list	C
0646T	Transcatheter tricuspid valve implantation (ttvi)/replacement with prosthetic valve, percutaneous approach, including right heart catheterization, temporary pacemaker insertion, and selective right ventricular or right atrial angiography, when performed	Add to the IPO list	C

IPO Procedures: Requests for Comment

- CMS requested comment on removing four gastric procedures currently on the IPO list:
  - 43775 (Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy [i.e., sleeve gastrectomy])
  - 43644 (Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy ([Roux limb 150 cm or less])
  - 43645 (Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption)
  - 44204 (Laparoscopy, surgical; colectomy, partial, with anastomosis)
- CMS said it did not receive comment indicating these procedures would be appropriate in an outpatient setting for the Medicare population
  - Maintained these procedures on the IPO list

Supervision of CR, ICR, and PR

- Supervision requirements for cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR), and pulmonary rehabilitation (PR)
  - Added physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNS) to the supervision provision of CR, ICR, and PR
    - Required under BBA of 2018, effective January 1, 2024
  - MPFS: Amending §410.47 (PR) and §410.49 (CR and ICR)
  - OPPS: Conforming changes to §410.27 section on direct supervision of CR, ICR, PR
    - Remove MD/DO requirement for supervision of CR, ICR, and PR
    - Add non-physician practitioners to the section on virtual presence through audio/video real-time communication
    - Extend the virtual presence exception through December 31, 2024, to match the extension under the CAA of 223

Payment of ICR in Off-Campus Departments

- Payment disparity for ICR between the physician office setting and off-campus provider-based departments (PBD)
  - ICR furnished in the office setting is paid at **100%** of the OPPS rate for CR (CY 2023: $120.47)
  - ICR furnished in an off-campus, non-excepted PBD (i.e., billed with modifier PN) is paid at **40%** of the OPPS rate (CY 2023: $48.03)
- CMS finalized the exclusion of **G0422 and G0423** for ICR from the off-campus adjustment regardless of the presence of the PN modifier
  - Result is payment at 100% of the OPPS amount

Miscellaneous Issues

- CMS did not take any action after reading comments regarding payment for maintaining a “buffer stock” of essential medicines
  - In the CY 2024 OPPS proposed rule, CMS identified 86 essential medicines
- CMS finalized its proposal to address updates in the MCE in April and October via transmittals similar to the I/OCE updates, rather than publishing them for comment in the IPPS rule-making cycle
  - Updates would be published by transmittal and include the changes included in the update similar to the I/OCE

Dental Services

- In the CY 2023 Medicare Physician Fee Schedule (MPFS) final rule, CMS did the following:
  - Distinguished dental services as the “care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth,” which are excluded services
  - Determined that there are instances where dental services are so integral to other medically necessary services that they are not in connection with the care, treatment, filling, removal, or replacement of teeth
    - These services are inextricably linked and substantially related to the clinical success of otherwise covered medical services
  - Specified dental services meeting the coverage requirements could be paid when provided before or in conjunction with:
    - Organ transplants, cardiac valve replacement, and valvuloplasty for CY 2023
    - Services related to the treatment of head and neck cancer for CY 2024 – finalized in the CY 2024 rule
  - Adopted a process to submit additional services for consideration in subsequent years

Dental Services

- In the CY 2024 MPFS final rule, CMS did the following:
  - Added to services allowing coverage of specified dental services:
    - Chemotherapy
    - Chimeric Antigen Receptor (CAR) -T cell therapy
    - Administration of high-dose bone-modifying agents (antiresorptive therapy)
  - Clarified that dental treatment required *following* direct treatment (radiation, chemo, surgery) for head and neck cancer to address oral complications arising from the treatment would also be covered
  - Noted that MACs have the flexibility to cover on a claim-by-claim (case-by-case) basis dental services for beneficiaries receiving other immunotherapies that involve lymphodepleting components – or other circumstances not specifically addressed

Dental Services

- In the CY 2024 MPFS final rule, CMS did the following:
  - Modified language in §411.15 (i)(3)(i)(A)
    - "Dental or oral examination performed as part of a comprehensive workup prior to, and medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, the following Medicare-covered services: organ transplant, hematopoietic stem cell transplant, bone marrow transplant, cardiac valve replacement, valvuloplasty procedures, *chemotherapy when used in the treatment of cancer, chimeric antigen receptor (CAR) T-cell therapy when used in the treatment of cancer, administration of high-dose bone-modifying agents (antiresorptive therapy) when used in the treatment of cancer.*"
  - Added new language in §411.15 (i)(3)(i)(D)
    - "Dental or oral examination performed as part of a comprehensive workup prior to, medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to or contemporaneously with, and medically necessary diagnostic and treatment services to address dental or oral complications after, treatment of head and neck cancer using radiation, chemotherapy, surgery, or any combination of these."

Dental Services

- CMS did not approve coverage for the following dental services for CY 2024:
  - Total joint arthroplasty
  - All cardiovascular procedures
  - Diabetes treatment
  - Treatment for sickle-cell anemia and hemophilia
  - Systemic autoimmune diseases
  - Treatment of leukemia and lymphoma in addition to other cancers
- CMS recommended commenters requesting services and diagnoses be included in the dental coverage policy submit appropriate evidence as outlined in the rule, by the February 10, 2024, deadline for consideration in the CY 2025 rule-making cycle

Dental Services

- CY 2023 OPPS final rule
  - CMS assigned 57 Current Dental Terminology (CDT) codes and 41899 (unlisted px dentalvlr strux) payable status indicators/APCs
  - CMS created G0330, facility services for dental rehabilitation procedures performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation [monitored anesthesia care]) and use of an operating room
    - APC 5871, SI: S, $1,722.43
- CY 2024 OPPS final rule
  - G0330 assigned to APC 5164, SI: J1, $3,070.81

Dental Services

- CY 2024 OPPS final rule
  - CMS assigned more than 200 dental codes to clinical APCs/covered status indicators – see Table 111
    - 41 codes assigned SI: J1 (C-APC)
    - 192 codes assigned SI: T (procedure subject to multiple procedure reduction)
    - 56 codes assigned SI: Q1 (conditionally packaged to S, T, or V status indicator services)
    - 10 codes assigned SI: 10 (unconditionally packaged)
  - If a dental code describes a service that has an existing CPT code, CMS instructed hospitals to continue to use the CPT code
  - CMS reemphasized that services must meet coverage requirements discussed in CY 2023-2024 MPFS final rules

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Non-OPPS Provisions Related to Price Transparency

Price Transparency

- The proposed rule's compliance timeline of 60 days was extended to six months or one year for specific requirements
  - See Table 151A for a timeline
  - See this repository for information on each requirement and its associated regulatory reference/compliance deadline: https://github.com/CMSgov/hospital-price-transparency
  - See this website for formats and data dictionary information: https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency/resources

Price Transparency

- Finalized standardization of machine-readable files (MRF)
  - CMS finalized its proposal to require hospitals to display standard charges using a CMS template, similar to the sample templates currently provided
    - CSV “wide” format
    - CSV “tall” format
    - JSON schema
  - “Encode” standard charge information in the following four required data element categories:
    - General information regarding the file
    - Hospital-specific information
    - Types of charges (gross charge, discounted cash price, payer-specific negotiated charge, estimated allowed amount, and min and max negotiated rates)
    - Data elements that enhance understanding of the items and services
  - See Table 84 of the proposed rule for required data elements compared to current templates

Price Transparency

- Finalized standardization of MRF
  - Types of charges
    - Payer-negotiated charges will require the following:
      - Payer/plan name
      - Type of contracting method
      - Whether the displayed amount is a defined dollar amount or based on a percentage or algorithm
        - » “Expected allowed amount” in dollars
      - Expected allowed amount requirements were delayed to January 1, 2025, with discussion in the final rule
  - Elements to enhance understanding
    - Facility vs. professional, inpatient vs. outpatient
    - “Billing” codes, revenue codes, and modifiers, including drug-specific units of measure
      - Drug units and modifiers were delayed to January 1, 2025, with discussion in the final rule

Price Transparency

- Finalized changes
  - Other “accessibility” issues
    - Include a .txt file in the root folder of the publicly available website where the MRF is posted
      - The .txt file would include the URL for the MRF and the webpage with the link to the file
    - Footer on the hospital’s homepage to link to the webpage with the MRF
  - New definitions for “CMS Template,” “Encode,” “Estimated allowed amount,” and “Machine-readable file (MRF)”
    - Conforming changes to refer to the “file” as a “digital file”
  - Replaced consumer-friendly expected allowed amount with “estimated allowed amount”
  - Attestation of accuracy and completeness
    - Hospitals will be required to affirm to the best of their knowledge and belief that all applicable standard charges information in their MRFs are “true, accurate, and complete” as of the date of posting

Price Transparency

- Finalized enforcement changes
  - A requirement for an authorized hospital official to submit to CMS a certification of the accuracy and completeness of the standard charge information – at any stage of the monitoring, assessment, or compliance phase
    - In addition to the “affirmation” within the MRF
    - CMS said this will help officials when a complainant alleges information is missing
  - Hospitals would have to provide the documentation necessary to assess the hospital’s compliance
    - In the proposed rule, CMS indicated this may include contracting documentation
  - Hospitals will also be required to acknowledge warning notices “in the form and manner, and by the deadline” specified in the notice of violation

Price Transparency

- Hospital system non-compliance
  - CMS finalized that if they take action against a hospital AND determine the hospital is part of a health system, they may do the following:
    - Contact the leadership of the system
    - Work with the system to address similar deficiencies for hospitals across the system
  - CMS plans to use data from the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) or the Chronic Conditions Data Warehouse (CCW) to determine if a hospital is part of a system
- Publication of Compliance Actions and Outcomes
  - CMS will publish information on assessments of hospital compliance, compliance actions taken against hospitals, status updates of those actions, outcomes, and any notices to health system leadership on its website

Price Transparency

- Request for comment on alignment of multiple “consumer-friendly” requirements
  - Transparency in coverage
    - Effective 1/1/23 and phased in over 2 years, group health plans are required to disclose personalized pricing information for covered items and services to enrollees through an online consumer tool (or paper if requested)
    - Estimates are provided in real-time based on the patient’s cost-sharing
  - No Surprises Act
  - ERISA requirements for price comparison information and good faith cost estimates originating from the CAA of 2021
  - Multiple questions on how the provisions fit together and patient awareness and use of the information
- CMS did nothing with them in the rule – no discussion at all

Mental Health Provisions in the CY 2024 OPPS Final Rule

Mental Health

Partial Hospitalization Program

- Partial Hospitalization Program (PHP)
  - Alternative to inpatient psychiatric care for acute conditions
  - Prescribed by a physician
  - Written treatment plan and periodically reviewed by a physician
  - Furnished by a hospital or community mental health center (CMHC)
  - Offers less than 24-hour care

Partial Hospitalization Program

- CMS finalized §4124(a) of Division FF of the CAA, 2023 to amend §1861(ff)(1)
  - Defined PHP services beginning on or after January 1, 2024
    - Minimum of 20 hours per week included in §424.24(e)(1)(i)
    - Initial physician certification within 18 days and recertification (no less than every 30 days)

Intensive Outpatient Program (IOP)

- Established based on §4124 of the Consolidated Appropriations Act, 2023
- Services effective January 1, 2024
- Intensive outpatient services provided by CMHCs specifically as an “incident to a physician’s service”
- Minimum of 9 hours per week and under the supervision of a physician
  - Treatment plans and periodic review
- No requirement for inpatient psychiatric care services
- Distinct and organized ambulatory services offered by hospitals, CMHCs, RHCs, or FQHCs

Intensive Outpatient Program

- CMS finalized the following IOP benefits and determined they are reasonable and necessary for the diagnosis of the patient:
  - Individual and group therapy with physicians and psychologists
  - Occupational therapy
  - Services by social workers, psychiatric nurses, and drugs/biologicals for therapeutic purposes
  - Activity therapy
  - Family counseling
  - Patient training and education
  - Diagnostic services

Intensive Outpatient Program

- CMS finalized the following:
  - Coverage under Medicare Part B services (incident to physician services at a hospital or CAH)
  - Certification requirement no less than every other month
  - Mirror the PHP certification and treatment plan content

PHP/IOP

- Finalized payment updates for PHP/IOP
  - Payment rate for PHP/IOP
    - Four separate PHP APC payment rates
      - CMHCs for three service days and CHMCs for four service days (APCs 5853 and 5854)
      - Hospital PHPs for three service days and hospital-based PHPs for four service days (APCs 5863 and 5864)
      - The rate for hospital-based PHP was calculated using the broader OPPS data set, which allowed CMS to capture data from claims not identified as PHP
    - Four separate IOP APC payment rates
      - CMHCs for three service days and one for CMHCs for four service days (APCs 5851 and 5852)
      - Hospital-based IOPs for three service days and hospital-based IOPs for four service days (APC 5861 and CPS 5862)
      - The APC rates for IOP are the same as their corresponding PHP rates

PHP/IOP

- Finalized PHP/IOP coding updates
  - NUBC established new condition code 92 for IOP claims
    - Used by hospitals and CMHCs
    - Condition code 41 will continue to be used by hospitals and required for CMHC PHP claims in CY 2024
  - **Removed code 90865 – Narcosynthesis** from the approved list of HCPCS codes for PHP/IOP
  - Added 29 new HCPCS codes for PHP/IOP
    - See Table 98
    - Added codes included six HCPCS codes describing services related to caregiver training

Other Mental Health Updates

- Remote mental health
  - Modified definition of C7900 (15-29 min) and C7901 (30-60 min) to remove the word “initial”
  - Clarified the add on code C7902 is added on to C7901 only
  - New untimed code C7903 for group therapy (other than of a multiple-family group)
- Daily Mental Health Composite
  - Cap on the aggregate payment for mental health services provided by one hospital to a single beneficiary on a single day
  - Was based on the single hospital-based PHP
  - CY2024 will be based on APC 5864 (hospital-based PHP [four or more services])

CY 2024 MPFS Final Rule

Mental Health

Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC)

- Marriage and Family Therapist (MFT):
  - Master's or doctorate degree qualifying for licensure or certification as MFT
  - Licensed/certified as MFT in the state in which furnishing services
  - Completion of two years of post-degree supervised clinical experience in MFT
  - Meets other requirements specified by the secretary
- Mental Health Counselor:
  - Master's or doctorate degree qualifying for licensure or certification as MHC, clinical professional counselor, professional counselor
  - Licensed/certified as MFT in the state in which furnishing services
  - Completion of two years of post-degree supervised clinical experience in MHC
  - Meets other requirements specified by the secretary
- Eligible to submit an enrollment application
- Once enrolled, eligible to submit dates of service on or after January 1, 2024

Marriage and Family Therapist (MFT)
Mental Health Counselors (MHC)

- Rendered for the diagnosis and treatment of mental illnesses
  - Legally authorized to perform under state law
  - Other than hospital inpatient services
  - Otherwise covered if furnished by or incident to a physician's professional services
- Paid 75% of psychologist's payment amount
- Excluded from payment under OPPS
- Inclusion as practitioners who may opt-out
- Added to the nonphysician practitioner definition
- Eligible telehealth practitioners
- Addiction counselors / professional counselors meeting MHC definition
- Added MFT and MHC services to RHC/FQHC definitions
- Revised code G0323 to add MFT and MHC

Psychotherapy for Crisis

- Implementing proposal to meet CAA 2023 requirement of HCPCS codes for payment of psychotherapy in crisis
  - G0017 Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than office setting); first 60 minutes
  - G0018 Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); each additional 30 minutes
- Implement fee schedule amount of 150% of current PFS of non-facility RVUs for 90839 and 90840
- Non-facility place of service codes can be found at https://www.cms.gov/medicare/coding-billing/place-of-service-codes

CY 2024 MPFS Final Rule

Payment Update

Payment Update

- 2024 conversion factor: **$32.74**
  - Decrease of $1.15 (3.4%)
  - 1.25% overall payment rate reduction (CAA 2023 mandate for 2024)
  - 2.18% reduction through budget neutrality adjustment for 2024

CY 2024 MPFS Final Rule

Care Management Services

Care Management Services

- **Three new care management service categories**
- Purpose: Identify and address social determinants of health (SDOH) needs
- SDOH: Economic and social condition(s) that influence the health of people and communities
- SDOH needs: “Identified by a billing practitioner as significantly limiting the practitioner’s ability to diagnose or treat the serious, high-risk condition/illness/disease addressed in the initiating visit”
- Examples adopted from CPT: “Food insecurity, transportation insecurity, housing insecurity, unreliable access to public utilities, when significantly limit the practitioner’s ability to diagnose or treat the serious, high-risk illness/condition/disease”
  - Not all-inclusive

Social Determinants of Health Risk Assessment

- G0136: Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months
- SDOH Risk Assessment is an assessment of known or suspected SDOH needs
  - Not performed in advance of visit/pre-appointment
  - Not required on the same day as an E&M or behavioral health visit
- In conjunction with outpatient E&M, Psychiatric Diagnostic Evaluation (90791), Health Behavior Assessment and Intervention (HBAI) codes, Annual Wellness Visit (AWV), Transitional Care Management E&M, hospital discharge visits
- Standardized tools used must include domains of food insecurity, housing insecurity, transportation needs, and utility difficulties. (May include additional domains as necessary)
- Identified SDOH needs must be documented in the medical record
  - Z codes encouraged but not required
- At a minimum, practitioners must use SDOH Risk Assessment results to refer patients to relevant resources and utilize them in medical decision-making

Community Health Integration (CHI)

- Minor change to final code descriptor remove E&M and add service element to address auxiliary staff identification of additional unmet needs
- G0019: CHI services performed by certified or trained auxiliary personnel, including community health work, under the direction of a physician or practitioner; 60 minutes per calendar month, in the following activities to address SDOH needs that are significantly limiting the ability to diagnose or treat problems addressed in an initiating visit:
  - *Person-centered assessments, patient-driven goal-setting; tailored support; care coordination; health education; self-advocacy skills; health access/system navigation; facilitating behavior change; social/emotional support; leveraging lived experience (*https://www.federalregister.gov/d/2023-24184/p-1078)
- G0022: CHI services, each additional 30 minutes per calendar month (list separately in addition to G0019)

Community Health Integration (CHI)

- Address SDOH factors that impact billing practitioner's ability to diagnose and treat health problems
- Billing practitioner performs initiating E&M, Annual Wellness Visit, or High-level E&M associated with Transitional Care Management
  - Establishes plan of care
  - Not observation, inpatient, or ED E&Ms
  - Must be a physician or practitioner with Incident To benefit category
- Monthly services are incident to the billing practitioner
  - Auxiliary personnel
    - Includes Community Health Workers contracted through Community Based Organizations
    - Trained / Certified / Licensed as necessary
    - General supervision
- Patient consent required – written or verbal; documented in chart; obtained by practitioner or auxiliary personnel
- Not while under a home health plan of care

Principal Illness Navigation (PIN)

- G0023: Principal Illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month, in the following activities:
  - *Person-centered assessment; identifying or referring patient to appropriate supportive services; practitioner, home, and community-based care coordination; health education; building patient self-advocacy skills; healthcare access/health system navigation; facilitating behavioral change; facilitating and providing social and emotional support; leverage knowledge of serious high-risk condition and/or lived experience

    *Please note this is a very abbreviated list of the activities. Please see the full code descriptor for complete activity details. (https://www.federalregister.gov/d/2023-24184/p-1282)
- G0024: Principal Illness Navigation services, additional 30 minutes per calendar month (list separately in addition to G0023)

Principal Illness Navigation-Peer Support (PIN-PS)

- Additional codes in the final rule to more accurately reflect work by peer support specialists based on feedback.
- Limited to the treatment of behavioral health conditions meeting the PIN definition of a high-risk condition
  - Can still receive G0023 and G0024 as long as auxiliary staff meets certification requirements
- G0140: Principal Illness Navigation-Peer Support (PIN-PS)by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities:
  - Person-centered interview; identifying and referring patient to appropriate supportive services; practitioner, home, community-based care communication; health education; building patient self-advocacy; developing and proposing strategies to meet person-centered treatment goals; facilitating and providing social and emotional support; leverage knowledge of serious, high-risk condition and/or lived experience (https://www.federalregister.gov/d/2023-24184/p-1303)
- G0146: Principal Illness Navigation-Peer Support, additional 30 minutes per calendar month (list in addition to G0140)

Principal Illness Navigation (PIN)

- Provide individualized assistance to identify appropriate practitioners and providers for care needs and support timely access to necessary care
- Patients with serious illness but may not have SDOH needs
  - Examples: cancer; COPD; CHF; dementia; HIV/AIDS; severe mental illness or SUD (not all-inclusive- final rule addressed comments indicating other illness likely to also qualify)
- Initiating visit – E&Ms, Psychiatric Diagnostic Evaluation (90791), Heath Behavior Assessment and Intervention codes (96xxx), Annual Wellness Visit, E&M portion of Transitional Care Management service
  - New initiating visit once a year
- Monthly services are incident to the billing practitioner
  - Auxiliary personnel
    - Includes Community Health Workers contracted through Community Based Organizations
    - Trained/Certified/Licensed as necessary
    - General supervision
- Patient consent required – written or verbal; documented in chart; obtained by practitioner or auxiliary personnel
- Practitioner may bill PIN more than once per month
- May not concurrently bill PIN and PIN-PS services
- Other care management services can be billed in the same month as PIN as long as time and effort are not counted more than once

General Care Management (G0511) – RHC/FQHC

- Services currently included in General Care Management (G0511) at an RHC/FQHC (paid at the average national non-facility MPFS rate for included codes):
  - Chronic Care Management (CCM) (99490, 99491, 99487)
  - Behavioral Health Integration (BHI) (99484)
  - Principal Care Management (PCM) (99424, 99425)
  - Chronic Pain Management (CPM) (G3002)
- Additional services to be included as part of final rule in General Care Management (G0511):
  - Remote Physiologic Monitoring (RPM) (99453, 99454. 99457, 99458, 99091)
  - Remote Therapeutic Monitoring (RTM) (98975, 98976, 98977. 98980, 98981)
  - Community Health Integration (CHI) (G0019, G0022)
  - Principal Illness Navigation (PIN) (G0023, G0024)
- Payment methodology G0511 finalized as the *weighted* (based on office utilization) average of national non-facility rate for included codes – $72.98 vs. $64.13 under prior non-weighted method

Medicare Physician Fee Schedule Final Rule 2024

Evaluation and Management Update

G2211: E&M Complexity Add-on Code

- G2211: Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition (Add-on code, list separately in addition to office/outpatient E/M visit).
- CMS finalized the following:
  - End payment moratorium on December 31, 2023
  - Change code to active as of January 1, 2024
  - Not payable with modifier-25

E&M Split/Shared Services

- CY 2024 Medicare billing of split/shared services definition of substantive portion:
  - More than half of the total time spent
  - Substantive part of the medical decision-making as defined by 2024 CPT E/M Guidelines
- Critical care continues to be more than half the total time only

Appropriate Use Criteria

- Appropriate Use Criteria (AUC) program
  - Evidence-based guidelines to select the most appropriate tests
  - CMS has been working towards implementing since mandated in 2014
  - Currently (since 2020) operating in educational and testing period
- Pausing the AUC program for reevaluation
  - No future date planned at this time
- Rescinding AUC regulations at §414.94
  - CMS plans to re-evaluate the program
    - Concerns with implementation

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Telehealth Update

Telehealth Consideration Analysis Process

- Telehealth Services Status Process
  - Submissions of proposed additions/deletions to the CY 2025 Telehealth list due to CMS no later than February 10, 2024.
- Five-step analysis process
  - Five steps to analyze additions/deletions to the telehealth status list
    - (1) Separately payable under PFS
    - (2) Subject to provisions of 1834(m)
    - (3) Review of HCPCS elements capable of being furnished via interactive telecommunications
    - (5) Service elements of requested HCPCS map to existing permanent telehealth HCPCS
    - (6) Clinical benefit analogous to clinical benefit in-person (only if step 4 is unmet)
- Status categories
    - Change from category 1, 2, or 3 to Permanent or Provisional
    - Currently on category 1 or 2 mapped to new Permanent category
    - Temporary or category 3 codes mapped to new Provisional category

Telehealth Extensions

- Telehealth flexibilities in place for PHE extended through **December 31, 2024**
  - Originating sites expansion
  - Eligible telehealth providers
    - OT, PT, SLP, Audiologists continue
  - Payment for Telehealth by FQHC and RHCs
  - Delay of in-person visit requirements for mental health telehealth
    - Including in RHCs and FQHCs
  - Audio-only telehealth (only for services on the list permitted via audio-only)

Telehealth

- Through CY 2024:
  - Removal of frequency limitations on subsequent inpatient and subsequent nursing facility visits and critical care consultation services
  - Continue direct supervision via real-time audio and visual interactive telecommunications
  - Allow teaching physicians a virtual presence in all teaching settings only in clinical instances when service is furnished virtually
  - Diabetes Self-Management Training (DSMT)
    - Eliminate the in-person requirement for injection training
    - Institutional providers to continue to bill claims for services rendered remotely by qualified staff (includes PT, OT, SLP, and Medical Nutrition Therapy in addition to DSMT)
    - Apply -95 modifier to claims
- January 1, 2024:
  - Place of service (POS) 02 Telehealth other than patient's home: continue at the facility rate
  - POS 10 Telehealth in patient's home: paid at non-facility rate
  - Clarification: Hospital-based clinician telehealth service to patients in the home report hospital POS and modifier 95
  - Clarification: PT, OT, and SLP distant site practitioners continue to report modifier -95 instead of a telehealth POS

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Enrollment Update

Enrollment

- General process
  - Complete enrollment application
    - Online: Provider Enrollment Chain and Ownership System (PECOS)
    - Paper application
      - CMS-855
      - Different versions for different purposes (855I for individuals; 855R to reassign benefits)
  - Collects information to validate eligibility to enroll as a Medicare-qualified provider https://www.cms.gov/medicare/provider-enrollment-and-certification
  - Enrollment actions
    - Initial enrollment
    - Revalidation
    - Reactivation
    - Change of ownership or information
      - Time requirements to submit updates to information
      - Penalties for not updating information is revocation

Enrollment Updates: Revocation Authorities

- Revocation authorities updated to ensure capture of all situations that put the Medicare Trust Fund and/or beneficiaries at risk.
  - §424.535(a)(1): Non-compliance: Change language from "…subpart P…" to "…in this title 42…"
  - §424.535(a)(15) as a new authority of revocation related to a civil judgment under the False Claims Act in the past 10 years
  - §424.535(a)(23) as a new authority based on violation of specified CFR regulations related to IDFTs, DMEPOS suppliers, OTPs, HIT suppliers, or MDPPs
  - §424.535(a)(17) relates to bad debt referred to the U.S. Dept of Treasury
    - Revisions made to language to remove debt no longer being collected and reword from "existing debt" to "failure to repay a debt"
- Updated enrollment denial reasons in §424.530(a) to apply the same revocation additions and revisions noted above

Enrollment Updates: Revocation Authorities

- Organizational changes to §424.535(g) regarding retroactive and non-retroactive revocation effective dates to clarify exceptions to the 30-day effective date policy
- §424.535(e) change 30 days to 15 days for termination of party responsible for adverse action

New Enrollment Status: Stay of Enrollment

- New status of **stay of enrollment** in §424.541
  - Used when:
    - Non-compliant with at least one enrollment requirement
    - Non-compliance can be corrected with the submission of change of information applications
  - Preliminary/interim
  - Still enrolled (“paused”)
  - Not treated as a sanction or adverse action
  - Notify in writing
  - No longer than 60 days
  - Claims submitted during the period of stay will be rejected
  - Claims may be resubmitted if:
    - CMS/contractor determined provider/supplier resumed compliance
    - Stay ends on or before 60th day

Enrollment: Shorten period for deactivation

- In the CY 2024 Home Health PPS final rule, CMS revised §424.540(a)(1) to shorten the period of non-billing which results in deactivation from 12 months to six.
  - The provider or supplier billing privileges are stopped and must be “reactivated”
  - The provider or supplier agreement is not affected by deactivation

Quality Updates

OPPS

- CMS finalized the following for the Hospital OQR Program measure set:
  - Modify the COVID-19 Vaccination Coverage Among Healthcare Personnel measure beginning with the CY 2024 reporting period
  - Modify the Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery measure beginning with the voluntary CY 2024 reporting period
  - Modify the Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients measure beginning with the CY 2024 reporting period
  - Adopt Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults
    - Voluntary reporting CY 2025; Mandatory reporting CY 2026
  - Amend multiple codified regulations to replace references to "Quality Net" with "CMS-designated information system" or "CMS Website"

Ambulatory Surgical Center Quality Reporting (ASCQR)

- Revised ASC payment system by 2.0 percentage points for an ASC that fails to submit data on quality measures
- Previously adopted ASCQR Program Measures were finalized, and no changes were made

Ambulatory Surgical Center Quality Reporting (ASCQR)

- CMS finalized the following for the ASCQR program:
  - Modify the COVID-19 Vaccination Coverage Among Health Care Personnel measure beginning with the CY 2024 reporting period
  - Modify the Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery measure with the voluntary CY 2024 reporting period
  - Modify the Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients measure beginning with the CY 2024 reporting period
  - Amend multiple codified regulations to replace references to "Quality Net" with "CMS-designated information system" or "CMS Website"

Ambulatory Surgical Center Quality Reporting (ASCQR)

- Not finalized:
  - Re-adopt with modification the ASC Facility Volume Data on Selected ASC Surgical Procedures measure beginning with the voluntary CY 2025 reporting and mandatory reporting beginning with the CY 2026.
  - Adopt the Risk Standardized Patient-Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary THA and/or TKA beginning with the voluntary CYs 2025 and 2026 reporting periods, and mandatory reporting beginning with the CY 2027. Voluntary reporting will continue through CY 2027 and mandatory reporting will begin with the CY 2028 reporting period for CY 2031 payment determination.

CY 2024 MPFS Final Rule

Quality Payment Program

Shared Savings - ACOs

- CMS finalized the following:
  - Moving ACOs toward digital measurement of quality by establishing CQM collection type and aligning Shared Savings with MIPS Promoting Interoperability requirements starting January 1, 2025
  - Financial benchmarking methodology for ACOs beginning January 1, 2024
    - Applying risk adjustment methodology to benchmark and performance years and eliminate negative regional adjustment to encourage participation in ACOs caring for complex high-cost beneficiaries beginning January 1, 2025
  - Adding a third step to the beneficiary assignment methodology to provide greater recognition to NPs, Pas, and CNS who deliver primary care services
  - Expected to increase participation by 10-20%
  - CMS will provide a list of beneficiaries to ACOs who are eligible for Medicare CQMSs each quarter throughout the performance year

ACOs

- Have the option to report quality data using:
  - CMS Web Interface measures
  - CQMs and/or
  - MIPS CQMs collection types for PY 2024
  - Medicare CQMs (new)
  - Have the option to report quality data using
  - Beginning in 2025 and subsequent PYs, ACOs will have the option to report quality data using:
    - eCQMs
    - MIPS CQMs
    - And or Medicare CQMs collection types

Quality: MIPS and Shared Savings

- Promoting Interoperability performance category
  - CMS finalized a one-year delay 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, 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.
    - Proposing to align with this new definition for QPP and the Medicare Promoting Interoperability Program
    - Proposing to remove the CEHRT threshold requirements for Shared Savings Program ACOs

Quality Payment Program: MIPS

- Five new proposed Merit-based Incentive System (MIPS) Value Pathways (MVPs)
  - 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

Quality: MIPS and Shared Savings

- Quality Measures
  - Finalized five new MVPs and modifications
    - This brings the total to 16
  - Finalized a 180-day (minimum) performance period for the Promoting Interoperability performance category
  - Finalized the Medicare CQMs for ACOs participating in the Medicare CQMs collection type for Shared Savings Program.

Quality: MIPS and Shared Savings

- CMS did not finalize an increase to the data completeness threshold for the 2027 performance period
- CMS did not finalize that Qualifying Alternative Payment Model (APM) Participant (QP) determinations are to be made at the individual clinician level
  - No policies that would increase the performance threshold
    - **Performance threshold will remain at 75 points for the 2024 performance period**

Quality: MIPS and Shared Savings

- Cost improvement scoring
  - Calculation
    - Finalized to calculate improvement scoring for the cost performance category at the category level without using statistical significance beginning with the CY 2023 performance period/2025 MIPS payment 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 CY 2023 performance period/2025 MIPS payment year
      - This update would also align with CMS' methodology for scoring improvement in the quality performance category

Quality: MIPS and Shared Savings

- Scoring
  - CMS finalized that the maximum cost improvement score of **one percentage point out of 100** will be available beginning with the **CY 2023 performance period/2025 MIPS payment year**
  - CMS finalized that the maximum cost improvement score available for the CY 2022 performance period/2024 MIPS payment year will be **zero percentage points**

Questions & Answers

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