HEALTHCARE REGULATORY ROUND-UP #77

# 2025 Proposed Rules Part 4: Medicare Physician Fee Schedule

August 21, 2024

# Introductions

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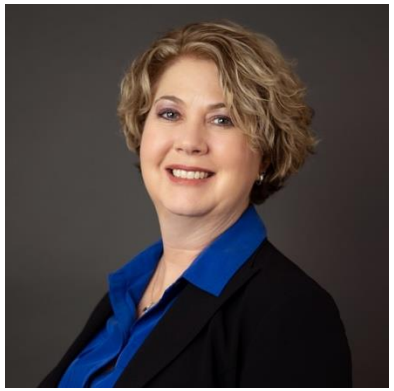

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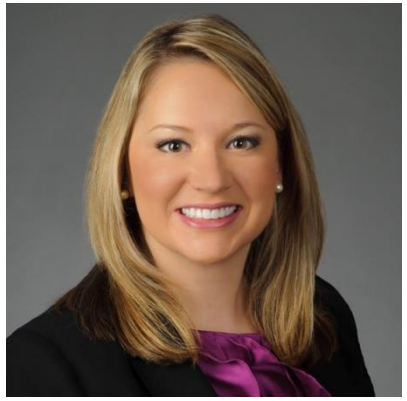

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## July 31 Webinar

1. CY 2025 Payment Rate Reduction
2. Deadline for Reporting Overpayments
3. Advanced Primary Care Management Payments
4. Telehealth
5. FQHCs/RHCs

## August 14 Webinar

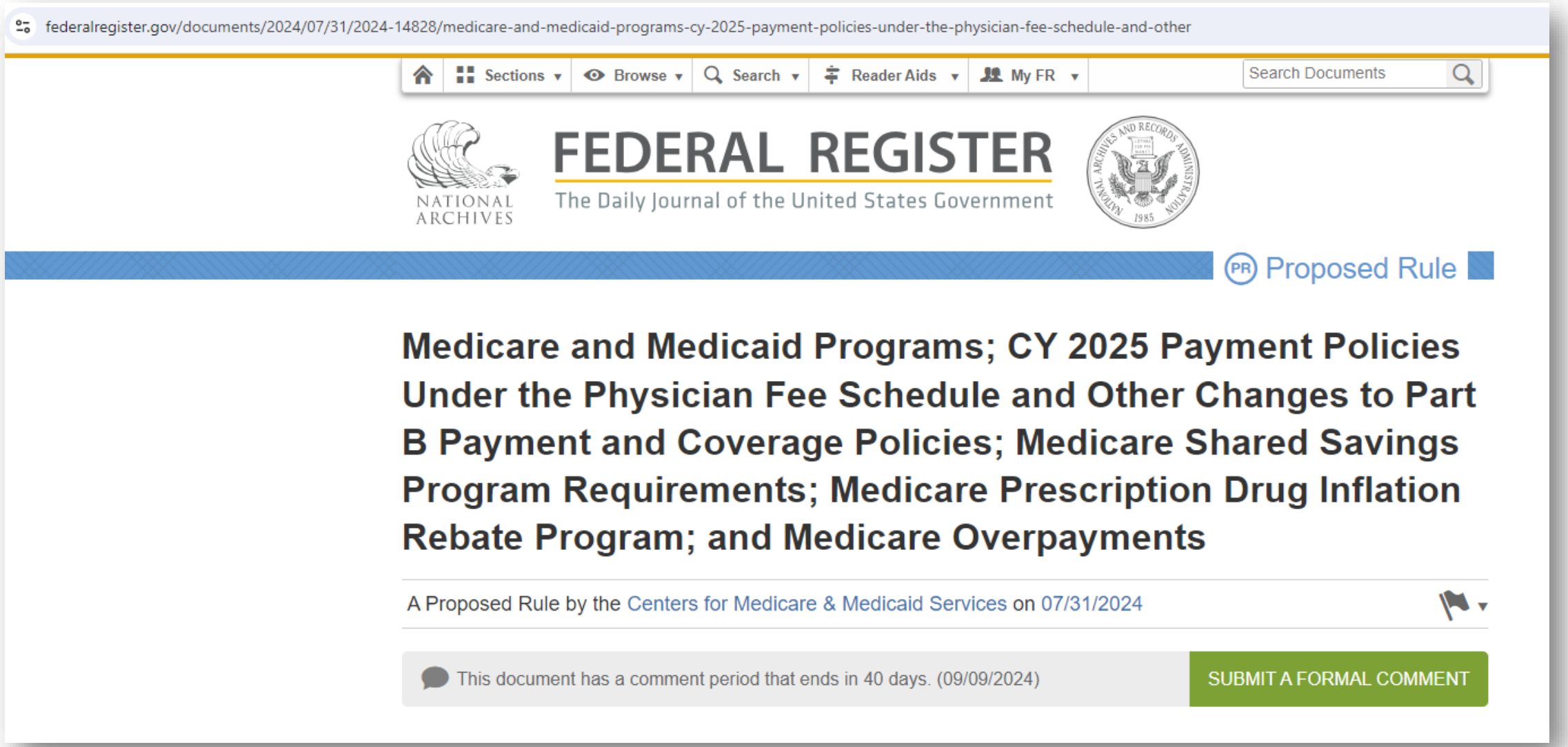
1. Global Surgery Payment Accuracy
2. E&M Services (Including HCPCS G2211)
3. New Payments for Preventive Services
4. Digital Therapeutics for Behavioral Health
5. Supervision of Outpatient Therapy Services
6. Opioid Treatment Programs
7. Skin Substitutes

**Recordings and slides for all HCRR webinars available at https://www.pyapc.com/healthcare-regulatory-roundup-webinars/**

# Today's Agenda

1. Quality Payment Program (MIPS)
2. CMMI Request for Information – Ambulatory Specialty Care Model
3. Medicare Shared Savings Program
4. SDOH-Related Services
5. Clinical Laboratory Fee Schedule Payment Reductions

**Comments on MPFS Proposed Rule due September 9, 2024**


federalregister.gov/documents/2024/07/31/2024-14828/medicare-and-medicaid-programs-cy-2025-payment-policies-under-the-physician-fee-schedule-and-other
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Proposed Rule
Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments
A Proposed Rule by the Centers for Medicare & Medicaid Services on 07/31/2024
This document has a comment period that ends in 40 days. (09/09/2024)
SUBMIT A FORMAL COMMENT

# 1. Quality Payment Program (MIPS)

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# MIPS Quality

- Data Completeness
  - 2025 – 2026: 75% as finalized in previous rulemaking
  - 2027 – 2028: proposed to hold at 75%
- 196 quality measures
  - Adding 9 measures, 2 = patient-reported outcome measures
  - Substantive changes to 66 existing measures
  - Removal of 11 measures from inventory
  - QCDR measures are approved outside of rulemaking and are not included in this count

# MIPS Quality

- Topped Out Measures
  - Proposing flat benchmark methodology to subset of topped out measures
    - Measures in specialty set with limited choices and high % of topped out measures that lack measure development which limits meaningful participation
  - Measures would be identified each year through rulemaking
  - Available points assigned for scoring >84% (1-1.9 points) up to 99.9% (8-8.9 points), with 100% achievement required to obtain 10 points
- Complex Organization Adjustment
  - Proposed to account for organizational complexities facing APM Entities and virtual groups when reporting eCQMs
  - Adds one achievement point for each summitted eCQM for these entities that meet data completeness and case minimum requirements
  - Capped: Adjustment cannot exceed 10% of total available achievement points in the Quality category

# MIPS Quality

- Minimum Criteria
  - Submission must include numerator + denominator for at least one quality measure to be considered data submission and thus scored
  - Intended to address scenarios where providers received zero score when limited data (e.g., only practice ID, date, or measure ID) was submitted
- APP Plus Quality Measure Set
  - Optional for MIPS eligible clinicians, groups, and APM entities
  - Required for MSSP which will be required to report measure set
  - If reporting, all measures in APP Plus Quality Measure set are required
  - Includes phased in addition of 5 Adult Universal Foundation measures – breast cancer screening (2025); colorectal cancer screening (2025); initiation and engagement of SUD treatment (2026); screening for social drivers of health (2028) and adult immunization status (2028).

# MIPS Quality

- Multiple Submissions
  - If from different organizations (e.g., practice and registry), CMS will calculate both scores and assign higher one
  - If from within same organization, CMS will score most recent submission and will override previous submission of same submission type
    - Wouldn't apply to different submission types by same organization
- MVP Population Health Measures
  - Proposing to score all population health measures and apply highest scoring

# MIPS Cost

- Add 6 episode-based cost measures with 20-episode case minimum
  - 1 acute inpatient medical condition measure (respiratory infection hospitalization)
  - 5 chronic condition measures (CKD, ESRD, kidney transplant management, prostate cancer, and rheumatoid arthritis)
- Substantive updates to 2 existing episode measures (cataract removal and inpatient percutaneous coronary intervention)
- Codifying removal criteria
- Substantive revisions to cost scoring methodology for **2024** performance year
  - Currently based on benchmark decile range and the corresponding percentile into which MIPS eligible clinician's cost performance falls
  - Proposing median set at 7.5 (performance threshold equivalent) and providers to be scored based on positive or negative standard deviation variance from median

# MIPS Improvement Activities

- Changes to current inventory of 106 IAs
  - Adding 2, modifying 2, removing 8
- Codifying removal criteria
- Remove weighting to simplify scoring
- Reduce number of required activities
  - MVP = 1 activity
  - Traditional MIPS w/ special status = 1 activity
  - All other traditional MIPS = 2 activities
- Minimum criteria – must include “yes” response for at least one IA activity
- Multiple submissions –
  - Submitted from different organizations – score all and apply highest
  - Submitted from same organization – score last submission received

# MIPS Promoting Interoperability

- Automatic reweighting of social workers continued to 2024 but will expire in 2025
- Automatic reweighting will only apply to special statuses (ASCs, hospital-based, non-patient facing, and small practice)
- Minimum criteria to include required elements
  - Performance data
  - Required attestations
  - CMS EHR Certification ID
  - Start and end date of applicable performance period
- Multiple Submissions – score all and apply highest
- Subgroup reporting – continuing existing policy that subgroup is required to submit its affiliated group's data for scoring (MVPs)

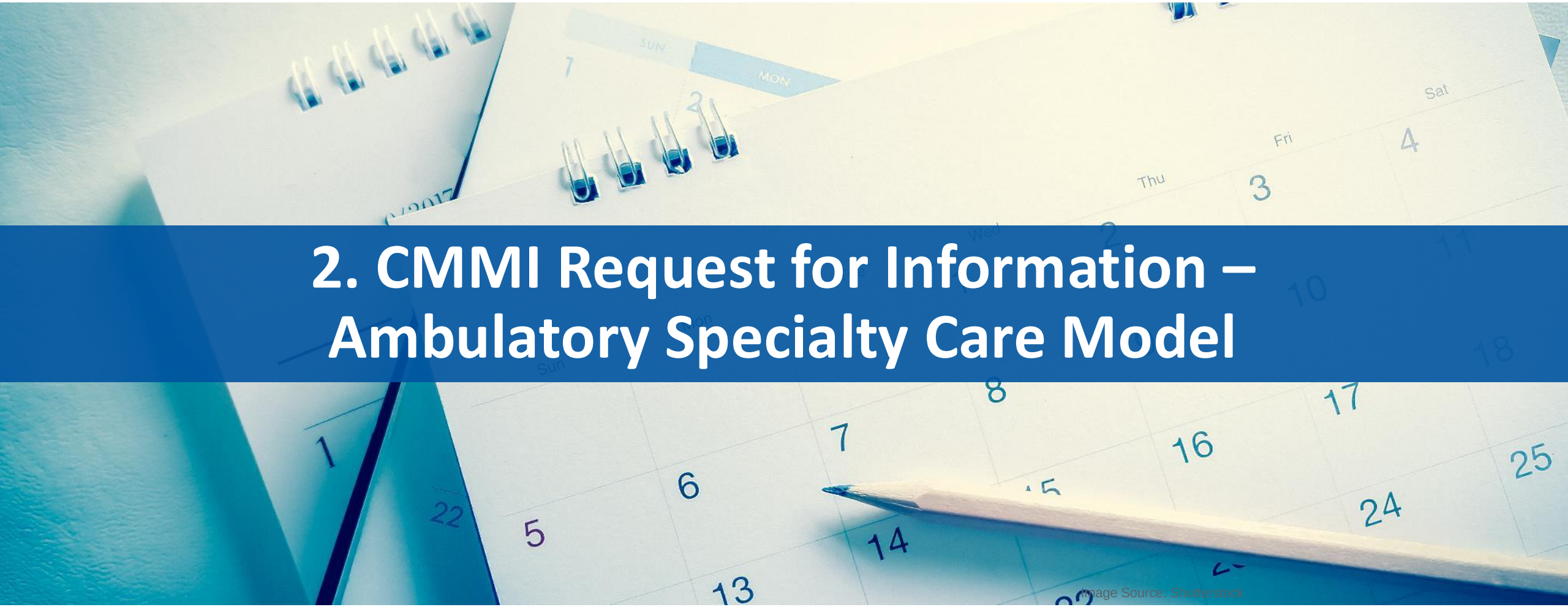
# MIPS Final Scoring

- Historically no reweighting policy to address when third-party did not submit data on behalf of clinician for reason outside the clinician's control
  - Opportunity to request reweighting where data are inaccessible and unable to be submitted due to reasons outside clinician's control because clinician delegated submission to 3rd party (written agreement required) and 3rd party did not submit by applicable deadlines
- CMS considerations include
  - Whether clinician knew or had reason to know of the issue
  - Whether clinician took reasonable efforts to address the issue
  - Whether issue caused no data to be submitted
- Requests would be submitted through QPP Service Center
  - Must be received prior to November 1 of the relevant **payment** year
  - Could be submitted beginning with CY 2024 performance period

# MIPS Value Pathways (MVPs)

- Goal = 80% of MIPS eligible clinicians have relevant MIPS pathway
- Continuing to pursue sunsetting of traditional MIPS
- Six newly proposed MVPS
  - Ophthalmology, dermatology, gastroenterology, pulmonology, urology, and surgical care
- Modifications to 16 currently finalized MVPs
- Consolidation of 2 neurology measures
  - Optimal Care for Patients with Episodic Neurological Conditions and the Supportive Care for Neurodegenerative Conditions MVPs

# 2. CMMI Request for Information – Ambulatory Specialty Care Model



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# MVP 2.0 – The Future of MIPS?

- Adjust participating specialist's payments based on MVP performance relative to all other participants in same specialty (or sub-specialty)
  - Currently, MIPS payment adjustment based on performance compared to single pool of all MIPS-eligible clinicians (different specialties, different measures, different methods of reporting)
- Request input on several matters
  - Participant selection - Which specialties should be prioritized? Should participation be mandatory?
  - Performance assessment
  - Payment methodology - What level of upward/downward adjustment needed to impact behavior?
  - Promoting partnerships with accountable care entities and primary care providers
  - HIT and data sharing
  - Health equity
  - Multi-payer alignment

# 3. Medicare Shared Savings Program

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# Pre-Paid Shared Savings Option

- Eligibility
  - Participate in Levels C-E of BASIC track or ENHANCED track
  - Record of meeting quality standards, not avoiding at-risk beneficiaries, recent shared savings
  - Submits supplemental application with detailed spend plan (updated annually)
- Amount calculated using detailed formula; paid out quarterly during performance period
- Use of Funds
  - May spend up to 100%, but not < 50%, each year on direct beneficiary services (address SDOH needs)
  - May spend up to 50% each year on staffing and healthcare infrastructure
  - Cannot spend funds on management/parent company profit, performance bonuses, provision of Medicare covered services, cash/gift cards to patients, items/activities unrelated to ACO operations/beneficiary care, repayment of shared losses
- Funds must be re-paid if shared savings not adequate to cover total amount
  - CMS will monitor ACO performance and discontinue payments if unlikely to receive shared savings

# Health Equity Benchmark Adjustment (HEBA)

- HEBA used in ACO REACH, credited with increasing safety net provider participation
- Upward adjustment to benchmark based on proportion of attributed beneficiaries enrolled in Part D low-income subsidy or dually eligible
- Will apply the highest of 3 potential adjustments:  HEBA, positive regional adjustment, prior savings adjustment

# Quality Measures

| Quality # | Measure Title | Collection Type | Performance Year Phase In |
|---|---|---|---|
| 321 | CAHPS for MIPS | CAHPS for MIPS Survey | 2025 |
| 479 | Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups | Administrative Claims | 2025 |
| 484 | Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions | Administrative Claims | 2025 |
| 001 | Diabetes: Hemoglobin A1c (HbA1c) Poor Control | eCQM/Medicare CQM | 2025 |
| 134 | Preventive Care and Screening: Screening for Depression and Follow-up Plan | eCQM/Medicare CQM | 2025 |
| 236 | Controlling High Blood Pressure | eCQM/Medicare CQM | 2025 |
| 113 | Colorectal Cancer Screening | eCQM/Medicare CQM | 2025 |
| 112 | Breast Cancer Screening | eCQM/Medicare CQM | 2025 |
| 305 | Initiation and Engagement of Substance Use Disorder Treatment | eCQM/Medicare CQM | 2026 |
| 487 | Screening for Social Drivers of Health | eCQM/Medicare CQM | 2028 |
| 493 | Adult Immunization Status | eCQM/Medicare CQM | 2028 |

- Changes to align with Universal Foundation measure set
- Beginning in 2025, ACOs must report on Alternative Payment Model Performance Pathway Plus (APP Plus)
  - eCQM = all patients; incentive extended for indefinite period
  - Medicare CQM = Medicare beneficiaries; eventually will be phased out

# Improper Payment Adjustments

- Adopt policy for making benchmark and expenditure adjustments based on identification of significant, anomalous and highly suspect billing activity (e.g., multi-billion-dollar catheter billing fraud identified by MSSP ACOs)
- Adopt calculation methodology to account for impact of improper payments in recalculating expenditures upon reopening  of initial payment determination
  - Establish process for ACOs to request such reopening

# Other Changes

- Beneficiary notification - must provide follow-up communication to beneficiaries within 180 days from date original notice provided
  - Current rule = earlier or 180 days or beneficiary's next primary care service visit
- Beneficiary attribution – inclusion of additional CPT/HCPCS codes as 'primary care services'
  - Safety planning interventions, post-discharge telephonic follow-up, virtual check-in, advanced primary care management services, cardiovascular risk assessment and management, interprofessional consultation, direct caregiver training, individual behavior management caregiver training
- Eligibility requirements – no longer terminate ACOs with fewer than 5,000 attributed beneficiaries (still required to enter into new agreement period)

# 4. SDOH-Related Services

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# SDOH Request for Information

- Community Health Integration Services (CHI) , Social Determinants of Health Risk Assessment (SDOH), and Principal Illness Navigation Services (PIN)
- CMS requesting feedback on additional policy refinements, other factors to consider
  - Any barriers to furnishing these services
  - Types of auxiliary personnel performing these services including certification and/or training requirement barriers
  - Any related services that may not be described by current coding finalized in 2024
  - Payment for these services and how to improve utilization in rural areas

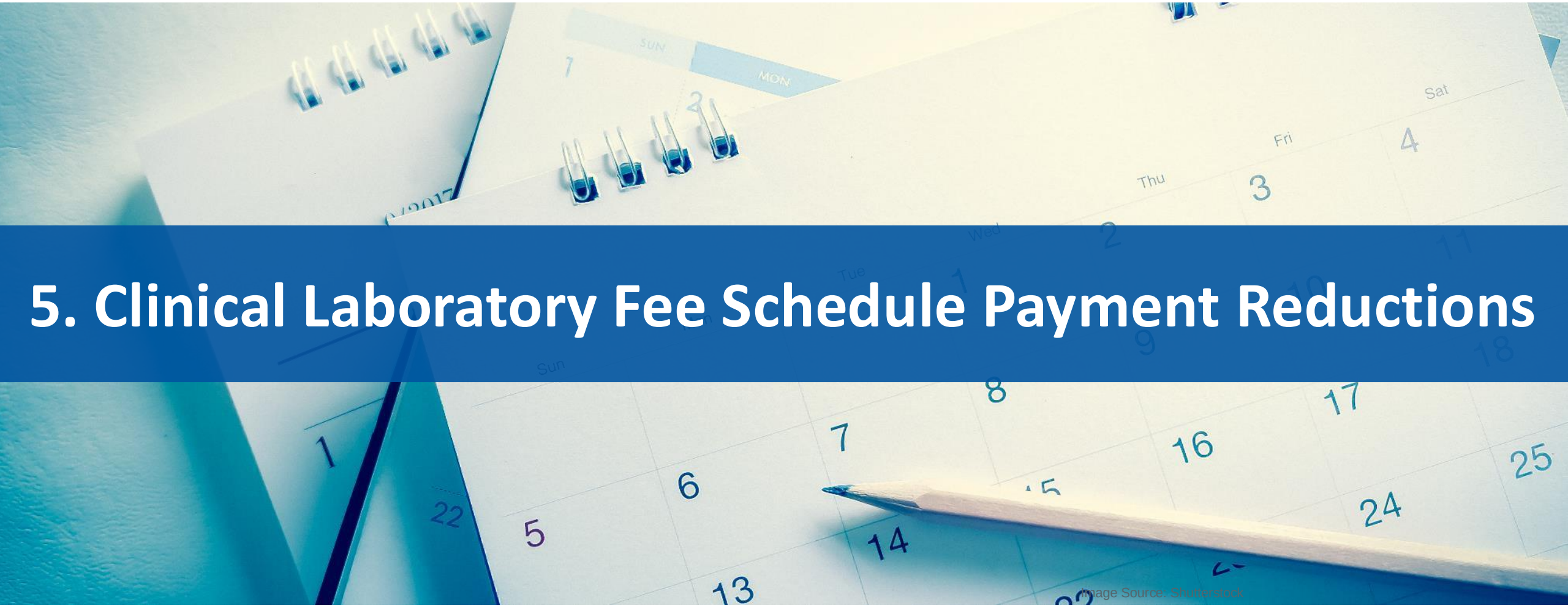
# SDOH Request for Information (continued)

- Any related services that may not be described by the current coding finalized in 2024.
- Are services described by codes allowing practitioners to better address unmet social needs that interfere with ability to diagnose and treat patient?
- Community- based organizations and their collaborative relationships with billing practitioners.
- Practitioners in geographically isolated communities (e.g., rural, tribal, and island communities) and otherwise underserved communities about coding Z codes on claims associated with billing for CHI, PIN, and SDOH risk assessment

# SDOH for Opioid Treatment Programs (OTPs)

- CMS requesting comments on inclusion of SDOH needs tool for individuals with opioid use disorder in OTPs
- If OTP furnishes SDOH risk assessments as part of initial assessment, tool should allow  OTP to identify more specific individual-level health related social needs as part of care plan (including potential harm reduction and recovery support services needs).
- Propose updating payment for intake activities (HCPCS G2076) to include value of non-facility rate for SDOH risk assessments (G0136)
- When OTPs bill G2076, should continue to perform initial assessment services consistent with SAMHSA certification requirements that already largely reflect SDOH risk assessment activities

# 5. Clinical Laboratory Fee Schedule Payment Reductions



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# PAMA History

- Protecting Access to Medicare Act (PAMA) implemented in 2014
- Preserved MPFS rates by reducing reimbursement in other areas
- Established reporting cycle
  - Issues with initial round of data collection
- New CLFS with single national rate based on private market data
- Capped reduction at 10% for CLFS payments (aggregate)

# Delay, Delay, Delay…

- 10% payment reduction cap remained for CYs 2019 and 2020 CLFS
- Congress implemented one-year delay on further reductions, effective January 1, 2021
- Congress extended “freeze” on CLFS payments from CYs 2022 through 2024

# Annual Reporting Periods

- PAMA's rate setting includes annual data reporting periods
  - Only two data collection periods and one reporting period so far
- Reporting pauses are result of various legislative measures
  - FCAA
  - CARES Act
  - PMAFSCA
  - CAA, 2023
  - FCAOEA, 2024

# Phase-in Reduction Plans

- Payment reductions over CYs 2025, 2026, and 2027,
  - Reduction cap increased to **15% per year.**
- Cap is based upon ***aggregate*** CLFS rates
  - Overall reduction is result of variety of CPT level adjustments
- Payment may not be reduced by more than 15% as compared to amount established for preceding year

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