Final 2024 Medicare Physician Fee Schedule Rule: *Key Changes for ACOs*

November 14, 2023

1:30 pm ET

Agenda

- Introductions
- Review of the final 2024 Medicare Physician Fee Schedule rule
  - Overview and key payment changes
  - MSSP policies:
    - Requests for Information
    - Benchmarking
    - Assignment
    - AIPs
    - Quality
  - QPP policies:
    - MIPS
    - Advanced APMs
- Audience Q&A

Webinar is being recorded

The recording and slides will be available on the NAACOS website within 48 hours.

Q&A will take place at the end of the program

You can submit written questions using the **“Questions” tab** (not chat) at any time during the webinar.

Speakers

	**Aisha Pittman** Senior Vice President, Government Affairs		**Jennifer Gasperini** Director, Regulatory and Quality Affairs
	**David Pittman** Director, Communications and Regulatory Affairs		**Robert Daley** Director, Legislative Affairs
	**Alyssa Neumann** Senior Analyst, Regulatory Affairs		

Overview and Key Payment Changes

Final 2024 MPFS Rule

- Final rule released November 2
- MSSP provisions address areas of NAACOS Advocacy:
  - ✓ Benchmarks: Eliminates negative regional adjustment, caps regional risk score
  - ✓ Quality: CQM reporting for Medicare-only; updates quality performance standard
  - ✓ RFIs: Enhanced+, ACPT improvements
  - ✓ AIP: Allows transition to risk in Basic Track, allows early renewal
- Other MSSP provisions:
  - Expanded assignment window
  - QP calculation changed to individual-level rather than ACO-level
- Other physician payment provisions:
  - Conversion factor decrease from $33.89 to $32.75 for 2024.
  - E&M visit add-on code for complexity (G2211)implementation with modifications.
  - New codes for community health integration services and social determinants of health (SDOH) risk assessment.

NAACOS Resources:

- Press release
- In-depth analysis coming soon
- Comments on proposed rule
- Email us your feedback– advocacy@naacos.com
- NAACOS Winter boot camps Feb. 8-9 in Orlando, FL

CMS Resources:

- CMS fact sheet
- MSSP fact sheet
- QPP factsheet
- CMS press release

Physician FFS payment

Topic	Final Policies
Payment	• Conversion factor of $32.74, a 3.4% decrease from 2023
Evaluation and Management Visits	• Complexity add-on code G2211; cannot be bundled with other services • Split visit: revising definition of substantive portion to mean more than half total time

Telehealth	• Service list additions: health and well being coaching (temporary); SDOH risk assessment
	• New process for analyzing requests for service additions
	• CAA 2023 provisions:
	  • Expansion of originating site
	  • Telehealth practitioner includes OT, PT, audiologists, speech-language pathologists
	  • Continuation for FQHC and RHC
	  • Delay requirement for in-person visit within 6 months prior to mental health telehealth services

Behavioral Health	• New HCPCS codes for psychotherapy for crisis • Health Behavioral Assessment and Intervention can be billed by social workers, MFTs, MHCs
Health Related Social Needs	• Pay separately for community health integration, SDOH risk assessment, principal illness navigation services • SDOH risk assessment optional additional AWV element with additional payment

Medicare Shared Savings Program (MSSP)

MSSP Potential Future Developments

CMS sought feedback on but did not propose any changes around the following topics. NAACOS offered comments on these RFIs, and a summary of comments received is available in section III.G.8. of the final rule.

RFIs	NAACOS Comments
Higher Risk Track than ENHANCED	• Push several concepts around "Enhanced Plus" including NPI-level participation, regional-only benchmarking, optional capitation, more waivers and flexibilities, and paper-based voluntary alignment.
Increasing Amount of Prior Savings Adjustment	• Increase maximum prior savings adjustment to 75%, risk adjust national FFS spending, use a quartile-based system to adjust caps based on ACOS' spending compared to its region
Expanding the ACPT Over Time and Addressing Market-Wide Ratchet Effects	• Use the ACPT as the national component of the trend adjustment • Remove ACO-assigned beneficiaries from the regional comparison
Promoting ACO and CBO collaboration	• Provide guidance and resources to ACOs working to partner with CBOs • Work to incorporate social risk into financial benchmarks to fund these activities

Financial Methodology

Summary of 2023 Changes

- CMS made several changes to MSSP's financial methodology in last year's Physician Fee Schedule
  - Added a prospective growth factor, called the Accountable Care Prospective Trend (ACPT), into a new three-way trend
  - Accounts for changes in ACOs' demographic risk scores before applying the 3% cap on HCC risk scores
  - Accounts for ACOs' savings generated in the previous agreement period when rebasing new benchmarks
  - Reduced the cap on negative regional adjustments to -1.5%
  - **All of CMS's benchmarking changes would take effect <u>for new agreements starting in 2024</u>**

Risk Adjustment

Final Policies	Comments/Key Issues
• Subject an ACO region's risk score growth to a 3% cap, just like ACOs themselves • Scale the cap to the ACO's market share within a region • ACOs in regions with risk score growth below the cap will not be affected • The region will be subject to a cap in risk scores, even if the ACO isn't	• This has been a long-standing advocacy point for NAACOS • **<u>Would only apply to new agreements starting in 2024</u>**

Risk Adjustment

Final Policies	Comments/Key Issues

• Blends the introduction of new HCC risk adjustment model version (V28) over three years
 	
• V28 would be:
  ○ ⅓ of risk scores in 2024
  ○ ⅔ of risk scores in 2025; and
  ○ 100% of risk scores in 2026
	• Similar three-year phase in done in Medicare Advantage
	
	• **Applies to all ACOs, regardless of starting a new agreement period or not**

• Codifies several risk adjustment policies	• Previously was very little in formal regulation on MSSP's risk adjustment policies

Risk Adjustment

Final Policies	Comments/Key Issues
• For new agreements, CMS will use the same risk model version in benchmark and performance years	• NAACOS advocated that ACOs would have been hurt by using different risk model versions in benchmark and performance years
• For existing agreements, benchmark year risk scores will be based on a different risk model version; This creates "model skew"	• CMS countered that new model phased in, regional adjustment still based off benchmark years, and all scores will be renormalized

Benchmarking

Final Policies	Comments/Key Issues
• Removes the negative regional adjustment, preventing an ACO's benchmark from being lower than it would be have been absent a regional adjustment • Prior savings add back not offset by negative regional adjustment	• Positive and helps attract ACOs with higher cost patients • ACOs who receive a negative regional adjustment are twice as likely to drop out of MSSP • Negative adjustment went from -5% to 1.5% to now being gone
• May change benchmarks through the prior savings adjustment in cases of compliance actions or revisions in shared savings amounts	

Beneficiary Assignment

- CMS finalized several changes (effective 1/1/25) to the claims-based assignment methodology and the approach for identifying assignable beneficiaries, including:
  1. Incorporating an expanded window for assignment, which includes the applicable 12-month assignment window and the preceding 12 months
     - Only applies to the new step 3
  2. Adding a step three to the beneficiary assignment methodology only for beneficiaries who:
     1) Do not meet the physician pre-step requirement;
     2) Receive at least one primary care service from an ACO physician during the expanded window AND
     3) Receive at least one primary care service from a non-physician ACO professional during the applicable 12-month assignment window
  3. Revising the definition of "assignable beneficiary" to include the expanded window for assignment
- CMS also finalized addition of several codes to the definition of primary care services used in assignment (effective 1/1/24)

Beneficiary Assignment

Key Issues:

- Intended to better account for beneficiaries who primarily receive primary care from NPPs within limitations of statutory requirement
- Builds on lessons from CMMI models with 2-year assignment window (e.g., REACH, Next Gen)
- Applied after current two-step methodology
- May result in some beneficiaries being prospectively assigned to an ACO under step 3 that differs from the retrospective ACO currently assigned
- May cause some ACOs to be identified as low revenue instead of high revenue
- Expands the assignable population, which is used to calculate national and regional factors

Beneficiary Assignment

Final Policies	Comments/Key Issues
Implement an "expanded window for assignment," which includes the applicable 12-month assignment window and the preceding 12 months	NAACOS raised concerns with lack of specialty information on care delivered by NPPs • Recommended solutions to distinguish between NPPs practicing in primary care vs. specialty settings
Add a step three to the claims-based assignment methodology	NAACOS supported • Encouraged CMS to monitor shifts in attribution
Revise the definition of "assignable beneficiary" to include the expanded window for assignment	NAACOS urged CMS to conduct additional analyses to mitigate unintended consequences from changes to assignable and assigned populations before implementation • CMS provided an expanded analysis with one additional year of data (PY 2019)

All finalized as proposed; effective January 1, 2025

Beneficiary Assignment

Final Policies	Comments/Key Issues
• Smoking and Tobacco-use Cessation Counseling Services (99406, 99407) • Cervical or Vaginal Cancer Screening (G0101) • Complex E/M Services Add-on (G2211) • Community Health Integration Services (G0019, G0022) • Principal Illness Navigation Services (G0023, G0024) • SDOH Risk Assessment (G0136) • Caregiver Behavioral Management Training (96202, 96203) • Caregiver Training Services (97550, 97551, 97552)	• NAACOS supported addition • CMS finalized as proposed
Office-Based Opioid Use Disorder Services (G2086, G2087, G2088) • Codes are excluded from CCLF files	• NAACOS opposed addition unless CMS provides this data to ACOs • CMS finalized as proposed, in response to comments: • "We encourage ACOs and ACO participants to establish their own processes to access patients' health information directly, in accordance with applicable laws for purposes of care coordination."
Remote Physiologic Monitoring (99457, 99458)	• CMS did not finalize addition • Cite commenters' concerns with codes shifting assignment to specialty care and data that show RPM is predominantly billed by cardiologists

Finalized additions effective January 1, 2024

Advance Investment Payments (AIP)

- In the final CY2023 MPFS rule, CMS finalized policies to provide upfront shared savings payments, called AIPs, to certain new ACOs beginning January 1, 2024, modeled after the ACO Investment Model
- NAACOS recommended several modifications to AIP policies in comments on the proposed CY2023 MPFS rule
- CMS finalized a handful of refinements to AIP policies in preparation for initial implementation of AIP in PY 2024, when the first ACOs receiving AIPs will begin their first agreement periods

Advance Investment Payments (AIPs)

Final Policies	Comments/Key Issues
Modify AIP eligibility requirements to allow ACOs to advance to performance-based risk (i.e., Levels C-E) in PY3 of the agreement period in which AIPs are received	NAACOS supported • Encouraged CMS further expand eligibility
Modify recoupment and recovery policies to allow ACOs receiving AIPs to early renew without having to immediately repay all AIPs	NAACOS supported • Recommended additional changes to recoupment policies
Amend termination policies to allow CMS to cease distribution of AIPs when an ACO provides notice of voluntary termination	NAACOS supported • Suggested CMS consider AIP use in termination policies
Require ACOs to report spend plan updates and AIP use to CMS	NAACOS supported
Permit reconsideration review of all quarterly payment calculations	NAACOS supported

All finalized as proposed; effective January 1, 2024

Eligibility and Technical Changes

Final Policies	Comments/Key Issues
Remove the option for ACOs to request an exception to the 75 percent shared governance requirement	NAACOS supported • CMS finalized w/modification to clarify that the exception applies to ACOs in agreement periods beginning before 1/1/24
Codify the current operational approach for determining whether an ACO participant has participated in a performance-based risk Medicare ACO initiative • Considers an ACO participant TIN to have participated if it was or will be included on a participant list used in financial reconciliation	NAACOS supported • Encouraged CMS to establish a process for participant TINs that had a small # of NPIs participating in a CMMI model to be considered inexperienced at the TIN-level • CMS finalized as proposed
Technical changes to references in MSSP regulations: • Clarify references to assignment methodology selection • Correct typographical errors • Updating outdated terminology on data sharing	NAACOS supported • CMS finalized as proposed

Finalized policies effective January 1, 2024

Quality Policies

Final Policy	Comments/Key Issues
Finalizes new Medicare CQM option, which allows MSSP ACOs to report only on Medicare FFS beneficiaries meeting assignment criteria, using MIPS CQMs for reporting: • Eligible for equity bonus • Not eligible for lower performance standard incentives offered for eCQM/MIPS CQM reporting in 2024	✓ Solves equity concerns by limiting to Medicare population only ✓ Reduces impact on specialty providers ✓ Reduces total population ACOs will be measured & scored on • Data aggregation challenges may still exist • Time limited option • **CMS will provide ACOs w quarterly lists of eligible patients w/ exclusion flags**

Medicare CQMs

Beneficiary eligible for Medicare CQMs = A Medicare FFS beneficiary who:

- Meets the criteria for a beneficiary to be assigned to an ACO; and
  - Had at least one claim w/ a DOS during the measurement period from an ACO professional who is a primary care physician or who has one of the specialty designations included at §425.402(c); or who is a PA, NP or CNS
- A Medicare FFS beneficiary who is voluntarily aligned to the ACO

Medicare CQMs

- **CMS will provide ACOs with a quarterly list of beneficiaries eligible for Medicare CQMs in the Quarterly Informational Report Packages**
  - List will be cumulative and updated quarterly to reflect the most recent quarter's data
  - 4th quarter list of beneficiaries will include encounters w DOS 1/1-12/31 of the performance year – delivered typically in Feb.
  - List will include age, diagnosis, encounter and exclusion flags (to extent info is avail through claims and administrative systems) – flags meant to assist and do not replace the need to evaluate patients for the denominator criteria

- **Medicare CQMs can be submitted by the ACO or a third-party intermediary**
  - Allows for use of multiple data sources (like MIPS CQMs) to compile numerator and denominator
  - CMS created identifiers that reflect the quality number followed by "SSP" which must be included in submission files (001SSP, 134SSP, 236SSP)

Medicare CQMs

Benchmarks

- For PY 2024 and 2025 CMS will score Medicare CQMs using performance period benchmarks since they will lack any historical data. In PY 2026, transitions to using historical benchmarks

Data Completeness

- For PY 2024, 2025, 2026 = 75% (CMS did not finalize increase in quality data completeness thresholds for MIPS)

Availability

- CMS expects that the sunsetting of Medicare CQMs may be paced w the uptake of FHIR API technology, but this will be assessed on industry readiness and CMS requirements

Other Final Quality Policies

Final Policy	Comments/Key Issues
Makes changes to the Quality Performance Standard (QPS) calculations to use a 3-year rolling average of historical performance data w/ a lag of 1 performance year	Allows ACOs to know QPS target ahead of the performance year starting (ex. for 224, CMS would use PY data 2020 – 2022)
Updates the APP measure specifications for MSSP for PY 2024	See Table Group E of Appendix 1 for specification changes for PY 2024
CMS intends to propose measure changes to align with the Universal Foundation set in PY 2025	UF set would include new measures on SDOH screening, adult immunization status & SUD treatment

Other Final Quality Policies

Final Policy	Comments/Key Issues
Changes suppressed measures policy for MSSP to ensure shared savings are not missed due to suppressed measure issues	Protects ACOs from missing shared savings due to measure suppression issues (problems with benchmarks, etc)
Requires Spanish language administration of the CAHPS for MIPS survey	Could increase survey participation
Modifications to health equity adjustment underserved multiplier	Exclude beneficiaries w/out a national ADI percentile rank from the underserved multiplier, effective for PY 2023 & use # of benes rather than person years for calculations

Polling Slide

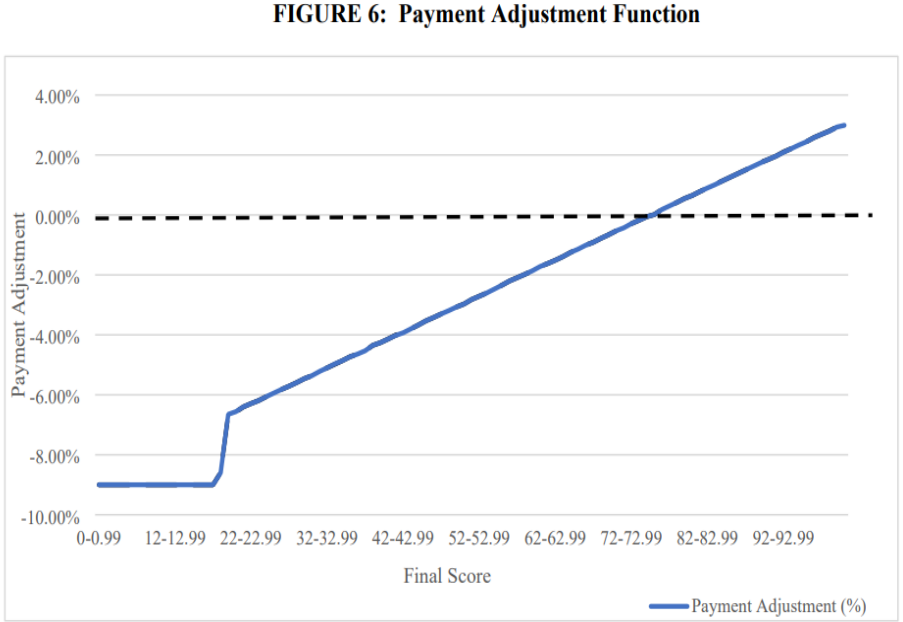
- Does the introduction of the Medicare CQM reporting option address your ACO's concerns with quality reporting requirements (sunsetting the Web Interface reporting option in PY 2025)?
  - Yes
  - No
  - Partially addresses concerns
- Will your ACO be ready to transition to eCQMs, MIPS CQMs or Medicare CQMs by PY 2025 (data reported in early 2026)?
  - Yes
  - No
  - Unsure

Quality Payment Program (QPP)

Merit-Based Incentive Payment System

Final Policy	Comments/Key Issues
Maintains the MIPS performance threshold at 75 points (no increase) for performance year 2024	Bonus point opportunities are limited, no exceptional performance bonuses
Did not finalize an increase in quality data completeness thresholds	Maintains current 75% data completeness thresholds through PY 2026
No changes to performance category weights for ACOs subject to MIPS	No changes

MIPS Adjustments



- CMS projects max MIPS adjustments of 2.9% for PY 2024/payment year 2026
  - Lower projections given the performance threshold will not rise

Aligning CEHRT Req's w MIPS

- **Aligns CEHRT requirements for MSSP ACOs with MIPS, resulting in removing the 75% requirement for ACOs but instead requiring all ACOs to report Promoting Interoperability**

- Sunsets the current 75% CEHRT use requirement for Advanced APMs and ACOs and replaces it with a requirement that to be an Advanced APM, the model must require all eligible clinicians in each participating APM Entity, or for APMs in which hospitals are the participants, each hospital, to use CEHRT

Aligning CEHRT Req's w MIPS

- **For PY 2025 and subsequent years**, unless otherwise excluded, an ACO participant, ACO provider/supplier, and ACO professional that is a MIPS eligible clinician, Qualifying APM Participant (QP) or Partial Qualifying APM Participant (Partial QP), regardless of track, must:

1. Report the MIPS Promoting Interoperability (PI) performance category measures and requirements to MIPS according to 42 CFR part 414, subpart O, at the individual, group, virtual group, or APM entity level
2. Earn a MIPS performance category score for the MIPS PI performance category

- **Advocacy resulted in a one-year delay – NAACOS will continue to push for the removal of this burdensome requirement**

Aligning CEHRT Req's w MIPS

- An ACO participant, ACO provider/supplier or ACO professional that is excluded from PI requirements does not need to report. Examples of exclusions include:
  - Low volume threshold
  - Do not meet MIPS eligible clinician definition
  - Qualify for reweighting of the PI category to zero as set forth at § 414.1380(c)(2) – clinical social worker, clinical psychologist, PT, OT, SLP, audiologist, registered dietitian
- See Table 31 for examples

Aligning CEHRT Req's w MIPS

- CMS encourages, but does not require, ACOs report PI at the APM Entity level
  - If reporting at individual or group level, will receive a weighted average score at the APM entity level
- CMS plans to provide subregulatory guidance to ACOs on how to report at the APM entity level in the future
- CMS also encourages ACOs to check their participants' MIPS eligibility before and during the PY to ensure they have up to date eligibility information (at qpp.coms.gov)

Aligning CEHRT Req's w MIPS

- If an ACO fails to meet these requirements, CMS may take remedial action before termination for noncompliance (warning notice, corrective action plan, or special monitoring plan)
- CMS notes participant agreements must allow the ACO to take remedial action against the ACO participant, including imposition of a corrective action plan, denial of incentive payments and termination of the ACO participation agreement detailed at §425.116(a)(7)
- ACOs must also publicly report total number of ACO participants, ACO providers/suppliers and ACO professionals that are MIPS eligible clinicians, QPs or Partial QPs that earn a MIPS PI score

Advanced APMs

Final Policies	Comments/Key Issues
CMS' current policy of making QP determinations at the APM-Entity will **remain in place for 2024** No changes will be made to the attribution methods for advanced APMs	NAACOS expressed concern that proposed changes to the QP determination from APM-Entity to NPI could discourage specialist participation in ACOs • NAACOS recommended using both methods until more universal ACO/ APM participation • Agency plans to conduct additional analysis and evaluations before making policy changes in future rulemaking
Updating the targeted review process timeline to allow 60 days for reviews of QP status once CMS begins implementation of QP conversion factor updates in PY 2026	Technical change to allow CMS time to adjudicate reviews and finalize list of QPs by Oct. 1

Advanced APM Incentive Payments

Final Policies	Comments/Key Issues
CMS is implementing a 3.5 percent advanced APM incentive payment extension for performance year 2023/ payment year 2025	NAACOS lobbied Congress to extend incentives prior to expiration at the end of 2022, which resulted in passage of one-year 3.5 percent extension NAACOS and stakeholders are calling on Congress to provide another extension of APM incentives
CMS is extending the freeze on APM qualifying thresholds for performance year 2023 • **QPs.** 50% payments 35% patient count • **Partial QPs.** 40% payment 25% patient count	NAACOS has successfully lobbied Congress to keep payment thresholds at 50% since 2020 • Under current law thresholds are scheduled to increase to 75% for payment threshold at the end of 2023 • NAACOS is working with lawmakers to address increase and give CMS more flexibility to set thresholds CMS predicts **316,000-407,000** QPs in 2024

Questions?

Upcoming Events

- Webinar: NAACOS Meeting of ACO Members

  November 15, 2023

  2:00 – 3:00 PM ET

  Register here!
- NAACOS Winter Boot Camps:

  February 8-9, 2023

  Marriott Orlando Airport Lakeside, FL

  Sign up here!

Thank you!

Please email advocacy@naacos.com with additional feedback or questions.