HEALTHCARE REGULATORY ROUND-UP #85

2025 Medicare Physician Fee Schedule Final Rule – Part 3

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Introductions

Martie Ross
Principal
mross@pyapc.com

Lori Foley
Principal
lfoley@pyapc.com

Sarah Bowman
Principal
sbowman@pyapc.com

Katie Croswell
Manager
kcroswell@pyapc.com

pyapc.com
800.270.9629

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November 20 Webinar

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

December 4 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. Medicare Shared Savings Program
3. SDOH-Related Services
4. Clinical Laboratory Fee Schedule Payment Reductions

1. Quality Payment Program (MIPS)

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MIPS Quality

- Data Completeness
  - Performance years 2025 – 2026: 75% as finalized in previous rulemaking
  - Performance years 2027 – 2028: finalized to hold at 75%
- Finalized 195 quality measures
  - Adding 7 measures, the 2 proposed patient-reported outcome measures were not finalized
  - Substantive changes to 66 existing measures
  - Removal of 10 measures from inventory
  - QCDR measures are approved outside of rulemaking and are not included in this count
  - Note that certain measures were added and deleted in prior years' rule making not included above

MIPS Quality

- Topped Out Measures
  - Adopted alternative 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% (9.9 points), with 100% achievement required to obtain 10 points
- Complex Organization Adjustment
  - Finalized to account for organizational complexities facing APM Entities and virtual groups when reporting eCQMs
  - Adds one measure 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

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- 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
  - Shared Savings Program ACOs which will be required to report measure set (current quality measure set will be unavailable beginning in 2025)
  - If reporting, all measures in APP Plus Quality Measure set are required
  - Modified timeline for 5 Adult Universal Foundation measures – breast cancer screening (2025); colorectal cancer screening (2026); initiation and engagement of SUD treatment (2027); 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 and score all measures received and pick the highest scoring measures to contribute to the quality score
  - 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
  - Finalized that CMS will score all population health measures and apply highest scoring
    - Participants no longer required to select population health measure during MVP registration

MIPS Cost

- Add 6 episode-based cost measures at the TIN and TIN/NPI level 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 (2025) and a new cost measure exclusion policy (2024)
- 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

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- Current inventory of 104 IAs
  - Adding 2, modifying 1, removing 4; also finalized removing 4 additional measures in 2026
- Codified removal criteria
- Removed weighting to simplify scoring
- Reduced 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 discontinues in 2025
- Automatic reweighting only applies 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

- Finalized proposal to allow 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 will be submitted through QPP Service Center
  - Must be received on or before November 1 of the relevant **payment** year
  - Can be submitted beginning with CY 2024 performance period
- Performance threshold continues to be set at the mean of 75 points

MIPS Value Pathways (MVPs)

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

2. Medicare Shared Savings Program

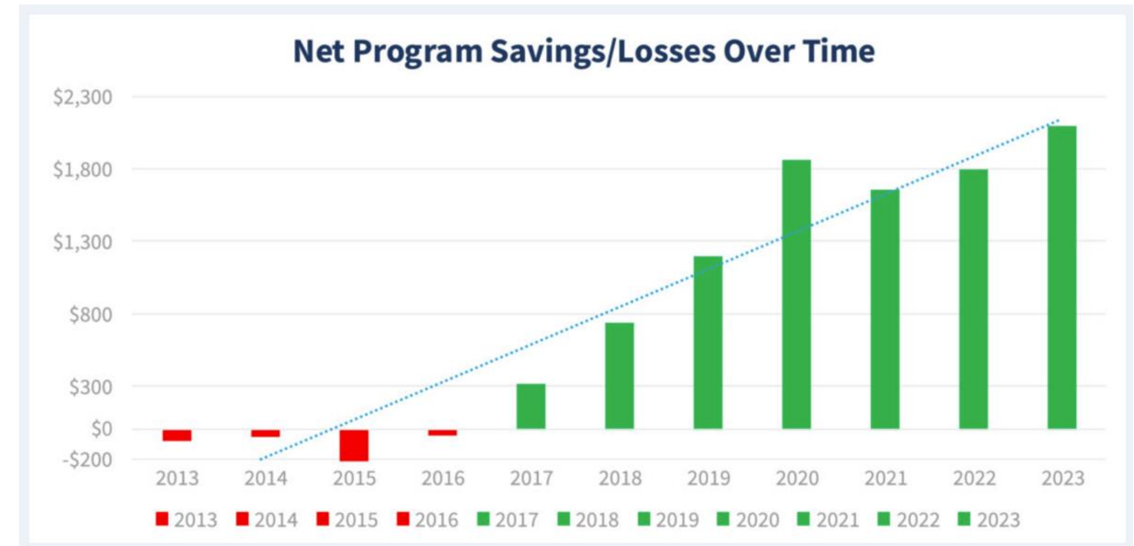
Image Source: Shutterstock

CMS' Continued Goal

- By 2030, 100% of traditional Medicare beneficiaries in a care relationship with accountability for quality and total cost of care
- Carrots, not sticks
- New administration?

2023 MSSP Financial Performance

- 453 ACOs participated in MSSP
  - 67% in two-sided risk models
  - 573K participating clinicians
  - 10.9M attributed beneficiaries
    - ~50% traditional Medicare beneficiaries
- ACOs reduced spending by $5.2B compared to adjusted historical benchmarks
  - 69% of ACOs earned shared savings, with payments totaling $3.1B
  - $2.1B net savings to Medicare program

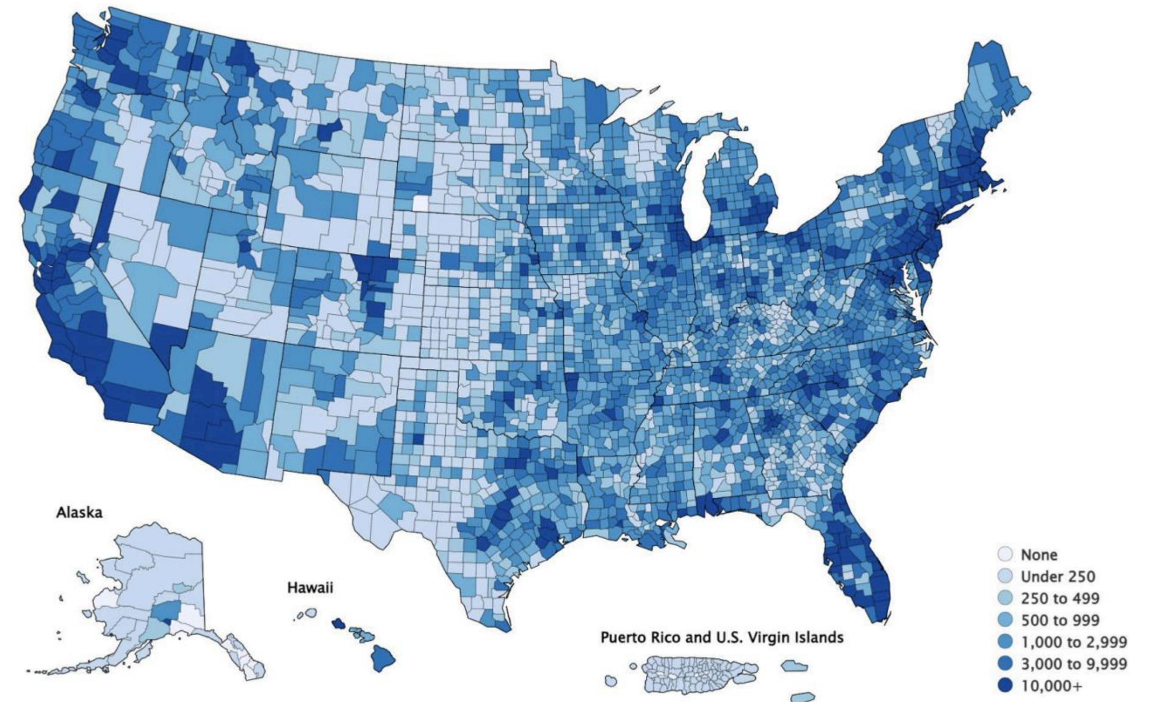


https://www.lumeris.com/insights/medicare-acos-show-value-based-care-is-thriving/

2024 MSSP Participation

480 MSSP ACOs

- 50 ACOs new to MSSP; 23 ACOs exited program
- 67% in two-sided risk models
- 609K participating clinicians
- 10.8M attributed beneficiaries (down from 2023)
- Significant increase in FQHC participation
  - From 4,409 in 2023 to 5,948 in 2024
- Advance Investment Payments
  - 19 ACOs serving underserved communities receiving $20M



https://www.cms.gov/files/document/2024-shared-savings-program-fast-facts.pdf

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
- May apply during annual application cycle beginning in 2026

Health Equity Benchmark Adjustment (HEBA)

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- 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 (LIS) or dually eligible for Medicaid + Medicare
  - To be eligible, at least 15% of attributed beneficiaries must be LIS 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
321	CAHPS for MIPS	CAHPS for MIPS Survey
479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims
001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	eCQM/MIPS CQM/Medicare CQM
134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM/Medicare CQM
236	Controlling High Blood Pressure	eCQM/MIPS CQM/Medicare CQM
112	Breast Cancer Screening	eCQM/MIPS CQM/Medicare CQM

- 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
- Additional eCQM/Medicare CQM measures to be added in future years
  - Add colorectal cancer screening in 2026

Improper Payment Adjustments

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- 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)

3. SDOH-Related Services

Image Source: Shutterstock

SDOH Background

- In CY 2024 MPFS Final Rule, CMS finalized G-codes to reflect new coding and payment for services
  - Community Health Integration (CHI) Services
  - Social Determinants of Health (SDOH) Risk Assessment
  - Principal Illness Navigation (PIN) Services
- In CY 2025 MPFS Proposed Rule, CMS requested feedback on additional policy refinements and other factors to consider for SDOH services

SDOH Service Clarifications

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- CMS believes current CHI and PIN coding accurately captures services CSWs currently provide.
  - Clarified that CSWs can provide CHI and PIN services and bill Medicare directly.
    - Not authorized to bill for these services when they are provided by auxiliary personnel incident to their professional services
  - These codes do not limit types of other health care professionals (e.g., RNs, social workers) who can perform CHI and PIN services incident to billing practitioner

SDOH Service Clarifications

- CMS sought comment on managing patients with fractures over the course of treatment using SDOH services. Comments included:
  - Some SDOH services like CHI or PIN do not accurately describe fracture liaison services.
  - The initiating visits for CHI and PIN may be barrier to care
- CMS clarified that when billing PIN services, there are circumstances in which osteoporosis may be considered a serious, high-risk disease expected to last at least 3 months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death.
- CMS will consider the commenters feedback related to SDOH services for future rulemaking.

4. Clinical Laboratory Fee Schedule Payment Reductions

Image Source: Shutterstock

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
  - CAEA, 2025

Phase-in Reduction Plans

- Revision - 0% payment reduction for CY 2025
- Payment reductions for CYs 2026, 2027, and 2028
  - Cannot be more than 15% as compared to amount established for preceding year
- Cap is based upon ***aggregate*** CLFS rates
  - Overall reduction is result of variety of CPT level adjustments

Our Next Healthcare Regulatory Round-Ups

January 15: Legislative Update + 2026 Medicare Advantage and Part D Proposed Rule

January 29: Deep Dive Into TEAM

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