Part B News
partbnews.com
COLLECT EVERY DOLLAR
YOUR PRACTICE DESERVES

IN THIS ISSUE

QPP changes arrive, as later reporting, payment hassles loom

Retention of key components confused commenters

When a practice uses the three key components, the service should be billed by the provider who performs at least one of the key components for a visit. However, under the 2023 update to the rest of the level-based code set, the history and physical exam will not be used to select the code. Several commenters asked about this discrepancy. According to CMS, when the visit includes a medically appropriate history and/or physical exam, a practice could count the performance of one or both service elements.

New definitions could be in the works

CMS split/shared policy is based on, but not identical to, the CPT guidelines for split/shared encounters. For example, CPT guidelines restrict split/shared coding to E/M visits based on time and do not dictate who bills the service. CMS does not allow split/shared billing for office visits. However, a future version of the guideline could be more aligned with CMS policy.

"The AMA indicated in its public comment letter that it intended to refer the definition of split (or shared) services back to CPT for potential further review," CMS writes in the final rule. CMS will review the changes and take them into consideration for possible future rulemaking.

Practices that use split/shared coding and split/shared billing should be certain that staff members understand the difference between the two types of split/shared. — *Julia Kyles, CPC (jkyles@decisionhealth.com)*

Quality Payment Program

QPP changes arrive, as later reporting, payment hassles loom

Take stock of a series of annual updates to the Quality Payment Program (QPP) and Merit-based Incentive Payment System (MIPS) to succeed in 2023, but watch carefully as CMS prepares for a whole new MIPS paradigm and, for alternative payment model (APM) participants, a possible year without bonuses down the road.

The 2023 numbers are no surprise: As proposed, the MIPS category weights will be 30% for Quality, 30% for Cost, 15% for Improvement Activities and 25% for Promoting Interoperability. The data completeness threshold rises from 70% to 75%, and the performance threshold remains 75 points. CMS finalized all its earlier proposed weights.

The most MIPS reporters can be penalized for missing these targets is 9% of payments, while the amount of the positive adjustment for meeting the reporting targets will be based on how many positive reporters are in the program — given the near-100% positive reporting rate in the program, positive adjustments are likely to be a very small amount. As for the additional positive payment adjustment for "exceptional performance," that is phased out starting in 2023.

A deeper look at the measures

Nine of the proposed new Quality measures were finalized, including "Improvement in Patient-Reported Itch Severity" for psoriasis and dermatitis patients; "Screening for Social Drivers of Health"; and "Adult Immunization Status." The agency cut 11 measures, including "Biopsy Follow-Up" and "Leg Pain After Lumbar Fusion," making the final tally 198 measures, down from 200.

In 2023, the Cost category score will be calculated by CMS based on achievement and a year-to-year improvement in the "Total Per Capita Cost (TPCC)" and "Medicare Spending Per Beneficiary (MSPB) Clinician" measures. (Previously, CMS notes, all participants received a score of zero "because we didn't calculate cost measure scores for the 2021 performance period" to base improvement on.) The maximum improvement score will be 1 percentage point out of 100 percentage points available.

To derive the final Cost score, CMS will "subtract the number of cost measures with a significant decline from the number of cost measures with a significant improvement, then divide the result by the number of cost measures for which the MIPS eligible clinician or group was scored for 2 consecutive performance periods, and then multiply the result by the maximum improvement score."

You will find four Improvement Activities added for 2023, including "Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients."

You'll see several tweaks to the Promoting Interoperability category. For example, the "Query of Prescription Drug Monitoring Program (PDMP)" measure, made optional in 2021, is now mandatory unless an exclusion on other grounds can be claimed. Of the

three active engagement options for measures within the Public Health and Clinical Data Exchange Objective, the first two, "Completed Registration to Submit Data" and "Testing and Validation," are combined as "Pre-production and Validation"; the third, "Production," becomes "Validated Data Production."

APM Entities reporting MIPS will be able to report Promoting Interoperability data at the entity level if they wish, while nurse practitioners, physician assistants, certified registered nurse anesthetists and clinical nurse specialists, previous exempted from reporting this category, will now be required to do so unless exempt for other reasons.

Bonuses remain uncertain

There are some technical changes to the Advanced APM alternative to MIPS — for example, the 8% Generally Applicable Nominal Risk standard for participants, through which eligible clinicians can become eligible for Qualifying APM Participant (QP) status, had been slated to expire but has instead been made permanent. But QPs will probably be more concerned with a potentially painful development scheduled for 2025.

Under the terms of MACRA, Advanced APMs that meet performance targets are supposed to get an annual 5% lump sum bonus, which in payment year 2026 will switch to a 0.75% increase in their Medicare Part B payments. Depending on how it's implemented, that change will probably mean a haircut for many APMs — but, more immediately, as 2024 is the last lump-sum payment year authorized by MACRA, and the law makes no provision for 2025, Advanced APMs will get no bonus at all in 2025.

Jamie Miller, senior director, government relations with the American Medical Group Association (AMGA), says that's not good for current Medicare Shared Savings ACOs or prospective ones. "We're hearing from our members who are currently in or thinking about joining the Advanced APM program that if the 5% bonus is gone that will impact their decision whether or not to stay in, or to go into value-based care in the first place," he says.

While Congress — which must make the fix — is notoriously slow to act, there are signs of a planned rescue. Suzanne M. Joy, senior public affairs advisor for Holland & Knight LLP in Washington, D.C., perceives "an appetite for larger APM/MACRA fixes" in Congress, and "there's a solid chance of APM bonus extension happening; it's at the top of wish lists for a lot of major health care orgs."

Joy also expects that there'll be conversations on Capitol Hill about "more overarching MACRA and fee schedule fixes — including lack of inflation-based updates and a budget neutrality requirement."

Mara McDermott, vice president of McDermott+Consulting and executive director of the Value-Based Care Coalition in Washington, D.C., notes that 44 members of Congress from both parties sent Speaker of the House Nancy Pelosi (D-Calif.) and Minority Leader Kevin McCarthy (R-Calif.) an open letter on Nov. 2 asking that the House pass by year's end the Value in Health Care Act (H.R. 4587) that would extend the 5% lump sum by five years.

MVPs on the way

MIPS reporters, meanwhile, might have their eyes on the progress of the MIPS Value Pathways (MVP) model that is intended to supplant the current system (*PBN 8/19/19*). Since its announcement in 2019, CMS has fiddled with MVP, which has fewer and broader reporting measures than the current model and in 2023 it will be available as a voluntary reporting method (*PBN 7/26/21*).

The program acquires five new MVPs, as the pathways that participants can choose are called: "Advancing Cancer Care," "Optimal Care for Kidney Health," "Optimal Care for Patients with Episodic Neurological Conditions," "Supportive Care for Neurodegenerative Conditions," and "Promoting Wellness."

These join the seven existing MVPs: "Advancing Care for Heart Disease," "Optimizing Chronic Disease Management," "Advancing Rheumatology Patient Care," "Improving Care for Lower Extremity Joint Repair," "Adopting Best Practices and Promoting Patient Safety within Emergency Medicine," "Patient Safety and Support of Positive Experiences with Anesthesia," and "Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes."

As in the current paradigm there are also Quality, Cost, Promoting Interoperability and Improvement Activity measures on which participants in each MVP will be scored, as well as Population Health measures. Participants may report as practice entities; due to the

specialty-specific nature of many MVPs, providers in multispecialty practices are allowed to create subgroups for reporting purposes.

Dave Halpert, chief, client team of Roji Health Intelligence, a consultancy and data registry in Chicago, expects some double-dippers among the voluntary reporters. "Since CMS will use the score most favorable to the clinician, groups — and subgroups — will give MVP reporting a test run, but will concurrently remain in traditional MIPS," Halpert says. "We have several clients who are planning to utilize this approach, as it enables them to gain subgroup reporting experience without risking their ongoing MIPS performance."

Lauren Patrick, president and CEO of qualified registry Healthmonix in Malvern, Pa., says that "if a group or subgroup is aligned well with one of the MVPs, those groups will want to report that MVP. In fact, they could achieve a higher score reporting the four relevant Quality measures within the MVP than if they report six measures for traditional group or individual MIPS reporting. So there is interest, from the perspective of only needing to report and improve the most relevant measures for a group." — *Roy Edroso* (redroso@decisionhealth.com)

RESOURCE

- Letter to House leadership on MACRA reform, Nov. 2, 2022: www.cms.gov/newsroom/press-releases/2022-letter-congressional-leaders-macra-reform.pdf

Shared Savings Program

Shared Savings offers rewards for ACOs in underserved areas, but others can benefit

By finalizing most of its proposed changes to the Medicare Shared Savings Program (MSSP), CMS is giving massive breaks to new and low-revenue accountable care organizations (ACO) that serve underserved communities, as well as enticements for others to stay. The agency evidently wants to bulk up enrollment, and some experts think it's worth a try.

The new deal for new entrants who meet targets associated with CMS' "health equity" goal of better care for such beneficiaries can be generous, including a one-time upfront payment of, potentially, hundreds of thousands of dollars, as well as quarterly bonuses over a two-year term.

MSSP is the mother ship for Medicare-sponsored ACOs. Its mix of no-risk, low-risk and high-risk tracks, rivaling the amount of bonus earnings such organizations can gain by saving CMS money on care of beneficiaries as well as the money they can conceivably lose if they fail to deliver such savings, has by both measures been a success since its inception in 2012.

According to an April 2022 CMS accounting, the program has "483 ACOs with over 525,000 participating clinicians serving more than 11 million Medicare beneficiaries." And it is delivering savings: a recent CMS report found it had spent $1.7 billion less in 2021 than the agency calculates it would have spent otherwise, making it "the fifth consecutive year the program has generated overall savings and high-quality performance results."

For a while CMS was pushing for MSSP ACOs to take on more risk, as seen in its Trump-era Pathways to Success program (*PBN Mog 8/23/18*). But then the program began to exhibit issues with recruitment and retention; other programs appeared to be drawing prospective entrants away; and many new entrants had trouble adjusting to even the most modest requirements of the program (*PBN 8/13/20*).

How the payments work

The biggest boost comes from Advanced Incentive Payments (AIP) that will go to "low revenue ACOs that are inexperienced with performance-based risk ... new to the Shared Savings Program ... and that serve underserved populations." Such ACOs will be eligible for a "one-time fixed payment of $250,000 and per beneficiary quarterly payments for the first 2 years of an ACO's 5-year agreement period," the final rule states.

To be considered for the upfront payments, ACOs need to submit a supplemental application and proposed spend plan; possible quarterly payments will be based on the ACO's beneficiaries' status under Medicare Part D low-income subsidy (LIS) norms and/or Medicare and Medicaid dual eligibility, or "the 0.09 national percentile rank of the census block group" where beneficiaries live.

"CMS is determined to get all traditional Medicare patients into an accountable care relationship by 2030," says Dave Halpert, chief, client team of Roji Health Intelligence, a consultancy and data registry in Chicago. "But the number of ACO participants has plateaued, and the number of patients in underserved communities is proportionately smaller than the nation at large."