MSN HEALTHCARE SOLUTIONS

RBMA Official Chapter | Radiology Business Management Association Florida

2024 MPFS Final Rule

Focus on Cost

Friday, February 2nd, 2024

Conversion Factor Reduction

CY 2024 Medicare Physician Fee Schedule (MPFS) Final Rule issued on 11.2.2023

Finalized 2024 conversion factor of $32.74

Factors	
CY 2023 CF	$ 33.89
CF w/o 2.5% increase (CY 2023 per CAA 2023)	$ 33.06
CY 2024 RVU budget neutrality adjustment	-2.18%
CY 2024 1.25% increase (per CAA 2023)	1.25%
CY 2024 CF	$ 32.74

A 3.4% (or $1.15) decrease from 2023 ($33.89)

FY 2023 Consolidated Appropriations Act (H.R. 2617)

- FY budget for 2023 signed by President Biden on 12.29.2022
- Increased the CF by 2.5% (2023 only)
  - Did not address budget neutrality reductions
  - Resulted in a new CY 2023 CF of $33.89
- Outlined a 1.25% increase in the CY 2024 CF
  - Effectively a -1.25% decrease in 2024 because the 2.5% increase for 2023 did not extend into 2024
- Delayed the -4% PAYGO sequestration until January 2025
- Continue 2% sequestration through the first 6 months of 2032
  - The last 6 months of 2032 will have a 0% reduction, thus ending this payment revision

Estimated Impact by Specialty (Table 118)

Specialty	Impact of wRVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Interventional Radiology	-1%	-3%	0%	-4%
Radiology	-1%	-2%	0%	-3%
Radation Oncology & Radiation Therapy Centers	0%	-2%	0%	-2%
Interventional Pain Management	0%	0%	0%	0%

- CMS acknowledges anesthesiology, interventional radiology, radiology, nuclear medicine, vascular & thoracic surgery, physical/occupational therapy & audiology have payment decreases
- Due to redistribution of payments to other specialties related to:
  - Complexity add-on code (G2211) for office/OP E/M service
  - Year 3 of clinical labor pricing update
  - Proposed adjustments to certain behavioral health services

Proposed Legislative Fix

- Strengthening Medicare for Patients and Providers Act (H.R. 2474)
  - A bipartisan bill that would provide a permanent annual inflationary physician payment update tied to the MEI
  - Introduced by Raul Ruiz, MD (CA-D), Ami Bera, MD (CA-D), Larry Bucshon, MD (IN-R), Mariannette Miller-Meeks (R-IA)
  - 4.14.2023: Referred to Subcommittee on Health by Committee on Energy & Commerce

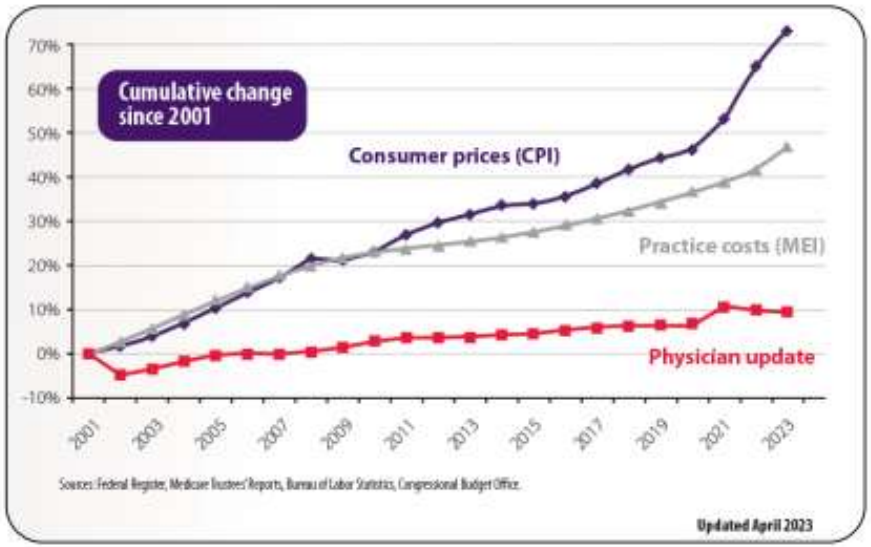
Medicare Economic Index (MEI)

- Government measure of inflation in medical practice costs
  - Developed in 1975
  - Resources used: annual changes in physicians' operating costs & physician compensation
  - To establish Medicare physician payment updates
- Confirms MEI increased at 4.6%
  - Highest increase this century
  - On top of a 3.8% increase in 2023

The Medicare Economic Index (ama-assn.org)

Medicare Economic Index

- Cumulative gap between MPFS updates & physician costs has already grown quite large
- Since 2001, physician payments have fallen 26% below the MEI



Appropriate Use Criteria

- Implementation of the Appropriate Use Criteria program is "paused"
  - Includes ending the current educational & operations testing period
- The operational challenge: the real-time claims processing aspect of the AUC program
  - Potential for claims to be denied inappropriately
  - The ACR is working with Congress to streamline & modernize the AUC program

Evaluation & Management

- E/M visits account for approximately 40% of all Medicare allowed charges
- Office/OP E/M visits represent 20%
- CMS has addressed 2 outstanding issues in this Final Rule:
  - Separate payment for G2211 (complexity add-on payment)
  - Definition of split or shared visits

E/M G2211

- "O/O E/M visit complexity add-on" code for 99202 - 99215
  - Established in the 2021 MPFS Final Rule
  - To better recognize the costs associated with E/M visits for primary & longitudinal care
    - Cannot be used if modifier 25 is appended to the E/M service
    - Additional payment of $16.04 (national)
  - Goal: increase patient compliance with treatment recommendations by building the practitioner-patient relationship
    - Previously unrecognized & unaccounted for during E/M visits

E/M G2211

- Cannot be billed with an office or OP E/M visit that is itself focused on a procedure or other service
- Focus:
  - Longitudinal care for all needed healthcare services, or
  - A single, serious or complex condition
  - The relationship between patient & clinician, not the characteristic of a certain patient
- Estimated 2024 utilization: 38% of all O/O E/M visits (54% when fully adopted)

G2211 Example #1

- Patient has a PCP
  - PCP is the ongoing focal point for all heath care services
- Patient sees PCP for sinus congestion
  - Complexity the code captures is not sinus congestion, the clinical condition
  - But rather the PCP's continued responsibility of being the focal point for all services

G2211 Example #2

- Relationship between clinician & patient for a specific condition
  - Specific to ongoing care associated with a serious or complex condition
- Patient has HIV & has an office visit with an infectious disease specialist
- Since the HIV specialist is part of the patient's ongoing care the visit becomes more complex
  - Even though the HIV specialist is not the focal point for all services, HIV is a single serious, &/or complex condition which requires compound building of considerations & decisions

E/M G2211 Use in Radiology

- It is possible this code could be used for some follow-up in complex interventional cases
- Example 1: there is a relationship with a patient for management of peripheral arterial disease (PAD)
  - This may start with the patient presenting for an initial service
  - Patient is treated with compression stockings
  - Patient is seen again with follow-up duplex exams, possible interventions
  - Continued follow-up after initial treatment to determine if additional treatment is needed

E/M G2211 Use in Radiology

- Example 2:
  - Long term care for nephrostomy catheters in a patient with urinary tract issues
  - Typically, these patients require tube changes every 3-4 months
  - If there are E/M encounters associated with these changes they would be candidates for use of the G2211

Split (or Shared) E/M Visits

- Definitions that align with the AMA's CPT E/M 2024 guidelines finalized
  - Clinicians may act as a team in providing care during a single E/M service
  - Whoever performs a "substantive" portion of the visit, may report the service
    - Based on total time: majority of the face-to-face or non-face-to-face time
    - Based on MDM: reported by whomever made or approved & takes responsibility for the management plan (this fulfills 2/3 elements)
      - Interpretation of tests & discussion of management plan must be personally performed by the clinician if these are used to determine the reported code
  - Exceptions:
    - Critical care visits: only based on time
    - Emergency department: always based on MDM

Virtual Supervision

- Provision of direct (level 2) supervision through real-time audio/video capabilities extended through 12.31.2024
- CMS has clarified the supervising practitioner does not need to be virtually present throughout the performance of the procedure
  - But must be immediately available to provide a virtual presence whenever necessary
- Comments:
  - No evidence virtual supervision causes patient safety or quality concerns
  - Virtual supervision makes workflows more efficient by freeing up practitioners' time
  - Data indicates there is no clinically meaningful statistical difference in patient outcomes for virtual direct supervision v. on-site direct supervision

Medicare Enrollment

- Enrollment definitions:
  - Deactivation = stoppage of billing privileges
  - Revocation = termination of billing privileges
- CMS has created of a new Medicare provider enrollment action labeled a "stay of enrollment"
  - A preliminary, interim status prior to any deactivation or revocation
  - Represents a pause in enrollment
  - Lasts no more than 60 days
  - Claims submitted during "stay" period will be rejected
    - Eligible for payment once "stay" period ends

Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule | CMS

Quality Payment Program 2024

The Quality Payment Program (cms.gov)

Themes Have Not Changed

- Minimal changes to MIPS – mostly "cleaning house" on measures
- Continues to emphasize health equity & reducing disparities
- Focus on electronic/digital data capture
- MIPS remains difficult to avoid a penalty with high rewards for strong performers
- Continues to build the MVP concept & inventory
  - Goal is to transition everyone from "Traditional MIPS" to MVP reporting
- Eventual goal is to have all providers in Advanced Alternative Payment Models (with downside risk)

QPP 2024 Overview

	2023				2024
	With Cost		Without Cost		
Category Weights (required by law)	>15 NPI Group	Small Practice	>15 NPI Group	Small Practice	No changes
Quality	55%	40%	85%	50%	
Cost	30%	30%	0%	0%	
Improvement Activities	15%	30%	15%	50%	

Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule | CMS

QPP 2024 Overview

	2023	2024
Penalty Threshold	75 points	75 points (proposal to increase to 82 rejected after public comment)
Complex Patient Bonus	0-10 points	No change
Quality Benchmarks	2021 performance drives 2023 published BMs	No change (2022 performance drives 2024 BMs)
	Retroactive BMs calculated from current year performance	Retroactive BMs calculated from current year performance
Quality Scoring	Measures with published BMs: 0-10 pts (3-10 for small practices)	Data completeness threshold increased to 75% (from 70%)
	New measures (Year 1): 7 pts minimum	Measures with data completeness <75% = 0 pts (3 for small practices)
	New measures (Year 2): 5 pts minimum	Proposal to increase to 80% in 2027 rejected
	For both, 5-10 if retro BM established	
	"Old" measures with no BM: 0 pts (3 pts for small groups)	

QPP 2024 Overview

	2023	2024
Quality Bonus	6 pts for small practices	No change
Quality Measures	198 national measures	198 national measures
		Radiology measures deleted: 147, 112, 113, 128, 324
		#436 remains for 2024; replaced with new eCQM measure in 2025 (#494)
Cost	TPCC, MSPB, 23 episode-based measures	TPCC, MSPB, 27 episode-based measures (5 added, 1 removed)
Improvement Activities	104 available	106 available (5 added, 3 removed, 1 changed)
MVPs	12 MVPs	5 MVPs added; 1 deleted - 16 total; none for Radiology

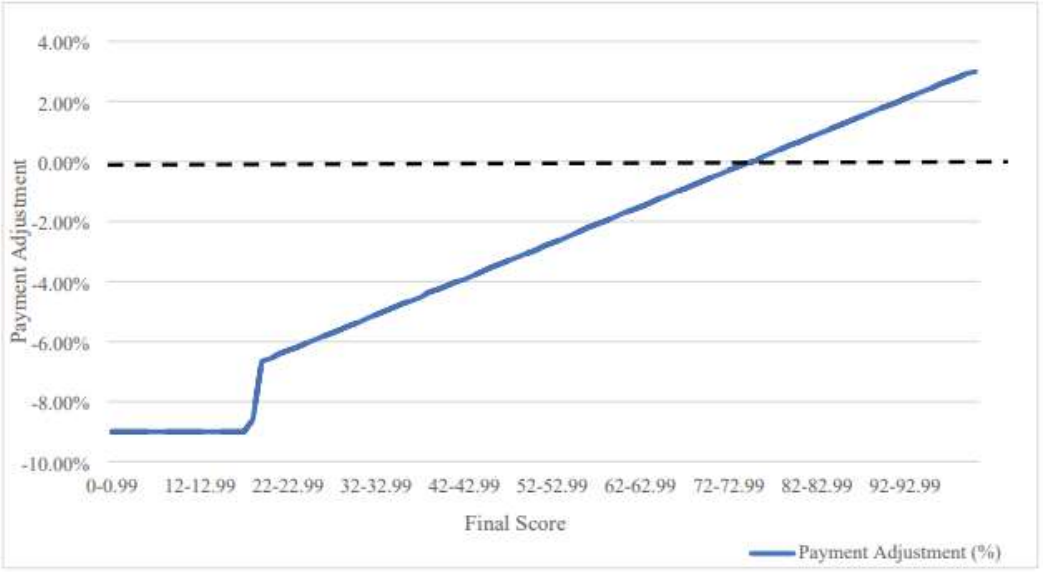
QPP 2024 Overview

	2023	2024
Public Reporting	Cost not publicly reported	Publicly report Cost performance in the future
APM Qualified Participant (QP)	QP status calculated at APM level	No change to QP determination methodology; Proposal was to calculate at the NPI level
	QPs earn 3.5% bonus; not MIPS-eligible	QPs earn 0% bonus & are not MIPS-eligible
	QP thresholds: Medicare payments & patients 50% & 35% respectively	QP thresholds: Medicare payments & patients 75% & 50% respectively
		QPs earn 0.75% conversion factor (portion of shared savings potentially only economic way to profit) vs. 0.25% received by non-QPs.
Promoting Interoperability	Scored on a 90-day performance period	Scored on a minimum 180-day performance period
		CEHRT & PI reporting threshold changes for MSSP ACOs delayed until 2025
		Modified exclusion for PDMP objective
		Safer attestation response must now be "Yes" to pass in 2024

Quality Payment Program - Economics

- Penalty threshold remains at **75**
  - Estimated payment adjustments range from -9% to +2.99% (100 pt score)
    - Down from 8.25% in 2022
    - Down from estimated max of 6% in 2023
  - Assumes 21.6% of industry will fail vs. 46.7% if threshold had been moved to 82 points as proposed

FIGURE 6: Payment Adjustment Function



Estimated CY 2024 distribution of payment adjustments to MIPS scores: -9% - 2.989%

Quality Measures Deleted

Measure #	Measure Description	Reason
147	Correlation with existing imaging studies for all patients undergoing bone scintigraphy	Topped out
324	Cardiac stress imaging not meeting appropriate use criteria: testing in asymptomatic, low-risk patients	Topped out
112	Breast cancer screening	Replaced with more robust composite measure (#497)*
113	Colorectal cancer screening	Replaced with more robust composite measure (#497)*
128	Body mass index (BMI) screening & follow-up plan	Replaced with more robust composite measure (#497)*

Other measures removed include: 14, 93, 107, 110, 111, 138, 283, 391, 402
*Duplicative of newly approved "Preventative Care and Wellness." A "composite" measure means it has multiple performance rates that must be reported (numerator values)

Quality Measure Not Deleted

Measure 436: Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques

- Lives to see another day!
- 2024 is the last year

Giving the industry one more year to prepare for the outcome measure that is set to replace 436

- **#494** (out of EHR) Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level)
  Requires the use of additional software to access primary data elements stored within radiology EHR records

Changes to Existing Quality Measures

Measure	Description	Changes
24	On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older	Denominator CPT codes updated
226	Tobacco Use: Screening and Cessation Intervention	**Age reduced from 18 to 12;** data completeness will be calculated from performance rate #1 (percentage of patients who were screened for tobacco use)
236	Controlling High Blood Pressure	Added clarity that patient reported values are allowed if automated machine is used to gather; relies on provider's discretion on what is acceptable.
317	Screening for High Blood Pressure & Follow-Up Documented	Denominator includes audiology codes
487	Screening for Social Determinants of Health	**Added an exception for patient reason screening was not performed** (e.g. patient refusal to complete questionnaire).
409	Clinical Outcome Post Endovascular Stroke Treatment	**Added exclusion for patients with baseline mRS >2**
493	Adult Immunization Status	Removed exclusions for patients receiving active chemo, bone marrow transplant, hx of immunocompromising conditions; added exception if 2nd zoster vaccine could not occur due to recommended 2-6 month interval between doses

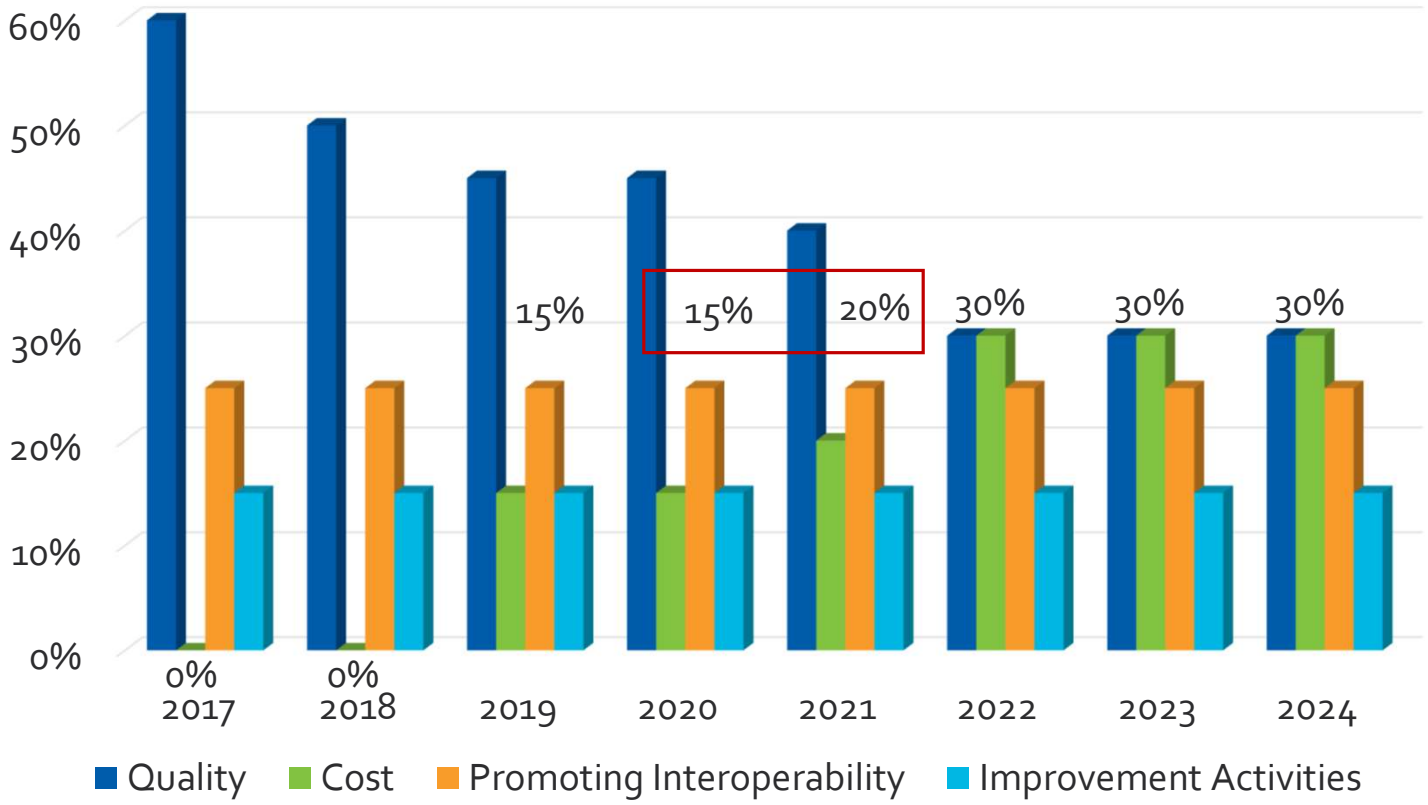
TIPS for SUCCESS with MIPS Quality

In 2024

- Thoughtful measure selection
  - Track at least 6 measures that have a published benchmark (example: 436)
  - Track at least 6 measures that are not devalued (example: 145)
- Implement/improve workflows now (prior to Jan. 1)
- Utilization of templates/macros
- Communication/Education to providers
- Remember to train new providers during the year
- Perfect performance on most of your quality measures is key
- Monitor regularly throughout the year to identify deficiencies

COST

Cost Performance Category



- Cost waived in 2020, 2021 due to Covid
- 2022 first year of full 30% impact
  - 30% of MSN QCDR Clients triggered Cost

Cost Category Basics

- 30% of your MIPS Score, if applicable
- It's not for everyone – but if you trigger just one cost measure – it's for YOU
- Calculated each year – only from Medicare Claims
- Each measure has a minimum eligibility threshold - if the number of patients/episodes attributed to your practice exceeds the threshold you will be scored on the measure.
- Each applicable measure = 10 possible points.
- Each cost measure has a benchmark - similar to quality - but instead of %s it's average cost ($).
- All cost measures applicable to you are weighted equally towards total cost score.
- 27 cost measures in 2024

2024 Episode-Based Cost Measures (27)

- Acute kidney injury requiring new IP dialysis
- Elective primary hip arthroplasty
- Femoral or inguinal hernia repair
- Hemodialysis access creation
- IP chronic obstructive pulmonary disease (COPD) exacerbation
- Lower gastrointestinal hemorrhage
- Lumbar spine fusion for degenerative disease, 1-3 levels
- Lumpectomy, partial mastectomy, simple mastectomy
- Non-emergent coronary artery bypass graft (CABG)
- Psychoses/related conditions
- Melanoma resection
- Colon & rectal resection
- Screening/surveillance colonoscopy
- Sepsis
- Elective OP percutaneous coronary intervention (PCI)
- Knee arthroplasty
- Revascularization for lower extremity chronic critical limb ischemia (RLECCLI)
- Routine cataract removal with intraocular lens (IOL) implantation
- Intracranial hemorrhage or cerebral infarction
- ST-elevation myocardial infarction (STEMI) w/ PCI
- Asthma/COPD
- Diabetes
- Psychoses & related conditions*
- Depression*
- Heart failure*
- Emergency medicine*
- Low back pain*

- *Historically triggered for groups with IR services*

*New measures added in 2024, the low back pain may apply to some radiology practices

Cost Measures Overview

Measure Name	Description	Case Minimum	Episode Window
Medicare Spending Per Beneficiary (MSPB)	Assesses cost of care for services related to qualifying IP hospital stays for Medicare patients	35 Medicare patient episodes	3 days pre-admission - 30 days post discharge
Total Per Capita Cost (TPCC)	Assesses overall cost of care for Medicare patients with a focus on primary care services; OP setting	20 Medicare patients	12 months from trigger E&M service
Revascularization for Lower Extremity Chronic Critical Limb Ischemia (RLECCLI)	Procedural episode-based measure that assesses the cost of care clinically related to revascularization procedures for Medicare patients with lower extremity chronic critical limb ischemia	10 Medicare patient episodes	30 days pre-procedure - 90 days post procedure
Hemodialysis Access Creation	Evaluates a clinician's risk adjusted cost to Medicare for patients who undergo a procedure for the creation of graft or fistula access for long-term hemodialysis	10-case minimum	Episode window starts 60 days before the trigger - 90 days after the trigger

Cost Measures Overview

Measure Name	Description	Case Minimum	Episode Window
Lumpectomy, partial mastectomy, simple mastectomy	Evaluates a clinician's risk-adjusted cost to Medicare for beneficiaries who undergo partial or total mastectomy for breast cancer	10-case minimum	30 days prior to trigger event – 90 days post
Low back pain (new in 2024)	Chronic condition; for OP treatment & ongoing management of low back pain	20-case minimum	At least 2 E/M services are billed with low back pain diagnosis in a 60-day global period (ASC/Office/HOPD)

New Episode-Based Cost Measure

- **Low back pain** (chronic condition): for OP treatment & ongoing management of low back pain
- Could trigger for radiology if:
  - At least 2 eligible services** are billed with low back pain diagnosis in a 60-day global period (ASC/Office/HOPD)* - this is the "trigger event"
    - First service is the "trigger code" – E&M
    - Second service is the "confirming code" – E&M or procedure/imaging
    - Once the 2nd service is billed the clock starts on a 120-day window ("attribution window") – where what you bill is analyzed

*2nd claim may be a condition-related CPT/HCPCS code related to the treatment or management of low back pain
** See measure code list from CMS for full list, but list includes OP E&M visit codes, x-ray, CT, MRI & some injections of spine CPTs. Both claims must also include chronic low back pain Dx Codes per code listing.

New Episode-Based Cost Measure

- If the relationship is ongoing (represented by 3rd E/M or condition-related procedure code in the 120-day window) this window can be extended
  - Referred to as the "reaffirming" claim
  - Clock starts again for another 120 days
  - If spine surgery occurs 90 days before a trigger code through 60 days after the relationship between the clinician & the patient is not initiated

- Only triggered if patient sees providers in the same TIN
  - 20-case minimum

Medicare Spend Per Beneficiary (MSPB)

(IP Medicare Cases only)

Attribution (Eligible Count):

- Surgical Admission* - to clinician group rendering any main procedure determined to be clinically relevant to the IP stay (see code listing)

- Medical Admission* - to clinician group providing at least 30% of IP E&M services (based on Medicare Part B claims)

Case Minimum = 35 episodes/year

* (based on admission DRG)

Medicare Spend Per Beneficiary (MSPB)
(IP Medicare Cases only)

Performance Calculation:

- Episode Window:
  - 3 days pre-admission thru 30 days post discharge
- Types of costs included:
  - Clinically related* Part A & Part B services (allowed amounts)

* *There are exclusions for services deemed unrelated to episode of care*
  - *Example: ER visit related to MVA 10 days post discharge*

** Applies to most groups who provide IP IR services **

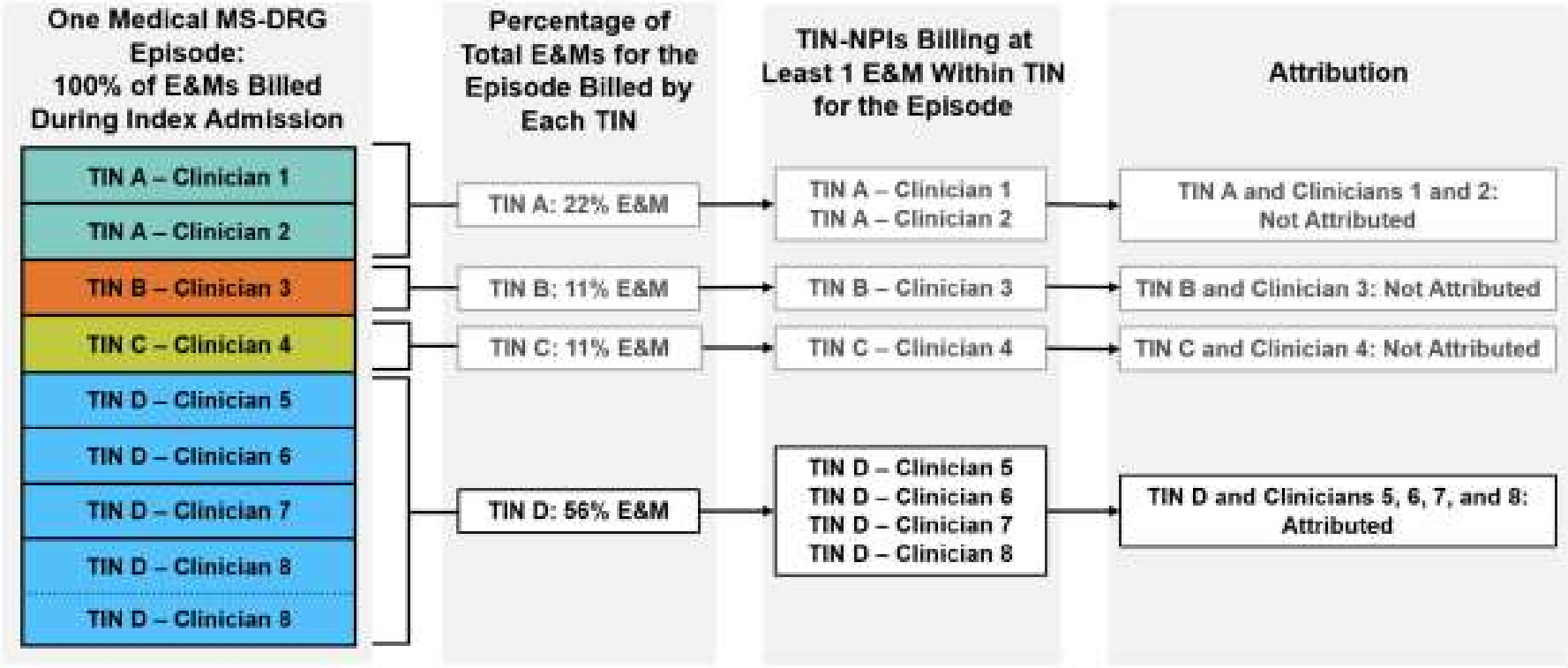
See Code Listing file from CMS for full list of surgical codes included in measure.

Common MSPB Relevant Surgical Codes

36573	Insertion of peripherally inserted central venous catheter (PICC)
36561	Insertion of tunneled central venous device with port
36556	Insertion of non-tunneled centrally inserted central venous catheter
36558	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump
36589	Removal of Central Venous Device
19083	US Guided breast biopsy
20206	Biopsy, muscle, percutaneous needle
50200	Renal biopsy; percutaneous, by trocar or needle
32550	Insertion of indwelling tunneled pleural catheter with cuff
32555	Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance
32557	Pleural drainage, percutaneous chest tube insertion
49083	Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance
36010	Introduction of catheter, superior or inferior vena cava
36245	Selective catheter placement, arterial system, each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family
36246	Selective catheter placement, arterial system, initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family
36247	Selective catheter placement, arterial system, initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family
36248	Add-on code, Selective catheter placement arterial system, additional second order, third order, and beyond abdominal, pelvic or lower extremity artery branch, within a vascular family
37244	Vascular embolization and occlusion for arterial or venous hemorrhage
37248	Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous; initial vein
37249	Add-on code, Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous; each additional vein
50432	Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed
50693	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, pre-existing nephrostomy tract

MSPB Medical

Figure B - 1. Diagram of E&Ms Billed within a Medical MS-DRG Episode



Revascularization for Lower Extremity Chronic Critical Limb Ischemia

(Episode-Based Cost Measure – IP or OP Setting)

Attribution (Eligible Count):

- Surgical procedures included in measure are linked to a provider:
  - Inpatient/Outpatient – attributed to the clinician billing the surgical CPT® code included in the measure

Case Minimum = 10 episodes/year

Revascularization for Lower Extremity Chronic Critical Limb Ischemia *(Episode-Based Cost Measure – IP or OP Setting)*

Performance Calculation

- Episode Window:
  - 30 days prior to trigger procedure thru 90 days post trigger procedure

- Types of costs included:
  - Clinically related* Part A & Part B services

* *There are exclusions for services deemed unrelated to episode of care*
  - *Example: ER visit related to MVA 10 days post discharge.*

** Applies to most groups billing for procedures included in the measure (see next slide) **

Revascularization for Lower Extremity Chronic Critical Limb Ischemia Cost Measure (RLCCLI)

Procedures included in measure

Code	Code Description
35302	Removal of blood clot and portion of superficial femoral artery
35303	Removal of blood clot and portion of popliteal artery
35304	Removal of blood clot and portion of tibioperoneal trunk artery
35305	Removal of blood clot and portion of tibial or peroneal artery, initial artery
35371	Removal of blood clot and portion of upper thigh artery
35372	Removal of blood clot and portion of deep upper thigh artery
35556	Bypass of diseased or blocked upper to lower leg artery with vein
35566	Bypass of diseased or blocked major upper to lower leg artery with vein
35570	Bypass of diseased or blocked lower leg to opposite lower leg artery with vein
35571	Bypass of diseased or blocked lower leg to lower leg artery with vein
35583	Bypass of diseased or blocked thigh to knee artery with vein graft
35585	Bypass of diseased or blocked upper leg to lower leg artery with vein graft
35587	Bypass of diseased or blocked lower leg to lower leg artery with vein graft
35656	Bypass of diseased or blocked upper leg to lower thigh artery with other than vein
35666	Bypass of diseased or blocked upper leg to lower leg artery with other than vein
35671	Bypass of diseased or blocked knee to lower leg arteries with other than vein
37224	Balloon dilation of artery of leg
37225	Removal of plaque in arteries of leg
37226	Insertion of stent in arteries of leg
37227	Removal of plaque and insertion of stents in arteries of leg
37228	Balloon dilation of artery of leg, initial vessel
37229	Removal of plaque in artery of leg, initial vessel
37230	Insertion of stent in artery of leg, initial vessel
37231	Removal of plaque and insertion of stents in artery of leg, initial vessel

Total Per Capita Cost Measure (TPCC)

(Outpatient Primary Care Focus – OP Medicare Cases only)

Attribution (Eligible Count):

Both steps must be met:

STEP 1 - Patient seen by PA/NP for an OP E&M service (see Primary E&M service list) AND

STEP 2 – Either of these two scenarios:

2a. Patient comes in again to a provider in the same TIN, within 90 days for another OP E&M service OR for another primary care-type service (see Primary Care Services list, which includes x-ray, US, mammo) OR

2b. Patient goes to someone outside your group and receives a primary care service +/- 3 days from the initial E&M in STEP 1 (service from either list).

Case Minimum = 20 episodes/year

Total Per Capita Cost Measure (TPCC)

(Outpatient Primary Care Focus – OP Medicare Cases only)

Performance Calculation

Episode Window – 12 months from trigger E&M service (Step 1).

Types of costs included – Medicare Part A and Part B services provided.

- Impacts groups using PAs/NPs to provide outpatient E&M services

Tackling Cost

- Understand which cost measures apply to your group
  - Compare billed CPTs to the attribution codes in the measure specification
- If you bill for outpatient E/M Services using NPs/PAs you are at risk of triggering the TPCC measure
  - If possible, try to avoid this practice
  - If you must use NPs/PAs in this way, try to use them for follow-up E&Ms, vs. the initial E/M visit
- For IP IR services
  - Think about complications these patients are at risk of developing & whether you can influence their prevention
  - Work with your Facilities to help manage patient cost where you can
  - Determine if the Facility's hospitalist billing practices are impacting you

Improvement Activities

Improvement Activities Deleted

Activity ID	Activity Title and Description	Activity Weight / Subcategory
IA_BMH_6	Implementation of co-location PCP and MH services	Medium / Behavioral and Mental Health
IA_BMH_13	Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment [MAT] for Opioid Use Disorder	Medium / Behavioral and Mental Health
IA_ PSPA_29	Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging	High / Patient Safety and Practice Assessment

Improvement Activities Added

Medium Weighted

- Improving practice capacity for human immunodeficiency virus (HIV) prevention services

High Weighted

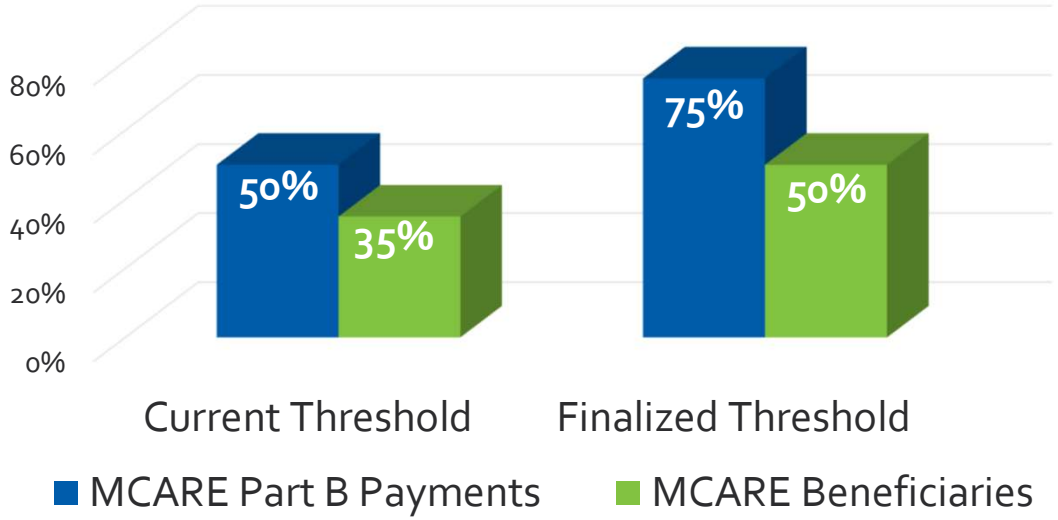
- Practice-wide quality improvement in MIPS Value Pathways
- Use of decision support to improve adherence to cervical cancer screening & management guidelines (submitted by CDC)
- Behavioral/mental health & substance use screening & referral for pregnant & postpartum women
- Behavioral/mental health & substance use screening & referral for older adults

MSN HEALTHCARE SOLUTIONS

Advanced Alterative Payment Models (APMs)

Major APM Provisions: QP Determination

- NOT passed: proposal to make QP determinations at the NPI-level rather than at the APM-Level
- Passed: increase to QP thresholds



Major APM Provisions: QP Determination

QPs:

- Not MIPS eligible
- Receive marginally higher conversion factor (0.75% vs. 0.25%).
- QP Incentive payment deleted in 2024
- Only opportunity to earn meaningful $ is through any portion of shared savings earned by your ACO & allocated to you (historically very minimal for Radiologists)

- Non-QPs:
  - Remain MIPS eligible
  - Receive 0.25% conversion factor
  - Have option to report MIPS independent of ACO – will receive higher of the two scores

MIPS Value Pathways (MVPs)

No MVP available for Radiologists in 2024

MIPS Value Pathways (MVPs)

- MVPs are the future
  - Being implemented so clinicians can report on measures that are directly relevant to their clinical practice
- Rather than selecting individual measures & activities from a large inventory that are reported under "siloed" MIPS performance categories . . .
- 1st available in 2023 performance year
- May report through MIPS & MVPs; CMS will take the higher score

MIPS Value Pathways (MVPs): Think of as a Bundle

- Providers/groups report on measures/activities linked to a specialty or patient condition
- Report fewer quality measures, but they tend to be more difficult measures
- Fewer choice of measures/activities vs. traditional MIPS
- Eventually must report an MVP for each specialty within your group (create sub-groups)
- Scoring, benchmarks, specialty statuses, etc. all the same as traditional MIPS

16 MVPs Available in 2024

MVP Description	Year Implemented
Advancing Rheumatology Patient Care	2023
Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes	2023
Advancing Care for Heart Disease	2023
Adopting Best Practices and Promoting Patient Safety within Emergency Medicine	2023
Improving Care for Lower Extremity Joint Repair	2023
Support of Positive Experiences with Anesthesia	2023
Advancing Cancer Care	2023
Optimal Care for Kidney Health	2023
Optimal Care for Patients with Episodic Neurological Conditions	2023
Supportive Care for Neurodegenerative Conditions	2023
Value in Primary Care	2023
Focusing on Women's Health	2024
Quality Care for the Treatment of Ear, Nose, and Throat Disorders	2024
Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV	2024
Quality Care in Mental Health and Substance Use Disorders	2024
Rehabilitative Support for Musculoskeletal Care	2024

Promoting Continuous Improvement

- CMS has always believed MIPS policies, requirements, & standards should be evaluated periodically for continuous performance improvement.
  - How can future policies support continuous improvement for clinicians who consistently perform well in MIPS?
- CMS seeks feedback on approaches to modifying MIPS policies, requirements, & standards
  - Will any changes be a burden?
- Going to continue to push for outcome measures, digital capture of performance . . .

One thing is for certain, the program is not going to get easier

Facility-Based Scoring

Facility-based scoring may be applied to facility-based clinicians & groups (incl. virtual)

- No reporting necessary – CMS calculates automatically for all facility-based clinicians
- To apply to groups, they must report IAs and/or PI measures.

Facility-based scoring will be used for your quality & cost scores when:

- You meet the definition of facility-based
- You are attributed to a facility with a Hospital Value-Based Purchasing (VBP) Program score
- The facility-based scoring methodology (using your Hospital VBP Program score) yields a higher final score than your final score calculated under MIPS

Facility-Based Determination

You are identified as facility-based if:

Individual:

- 75% or more of covered professional services are provided in inpatient hospital (POS 21) or on-campus outpatient hospital (POS 22) or emergency room (POS 23), and
- At least one service is billed with POS 21 or 23

Group:

- At least 75% of MIPS eligible clinicians billing under the group's TIN are identified as facility-based

** Very few radiology groups have benefitted from facility-based scoring **

Do NOT rely solely on FB scoring to protect you from financial loss

Key Takeaways

- Success is defined by achieving a MIPS score above the penalty threshold
- Thoughtful measure selection is critical
  - Very difficult to avoid a penalty using only National radiology measures
  - Try & find full value measures (e.g. QCDR measures)
- Perfect performance is a must
  - Use templates, implement early, monitor regularly, addend reports when feasible

Key Takeaways

- Understand which cost measures & patient populations apply to your group and develop a strategy/plan for each cost measure.

- If you're in an ACO, re-evaluate each year to assess if this is still the right choice for you

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Thank You

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