Centers for Medicare & Medicaid Services

Open Door Forum: Physicians, Nurses and Allied Health Professionals

Moderator: Jill Darling

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2:00 p.m. ET

Coordinator: Welcome, and thank you for standing by. Today's call is being recorded. If you have any objections, you may disconnect at this time. All participants are in listen-only mode until the question-and-answer session of today's call. At that time, you may press Star 1 to ask a question. I would now like to turn the call over to Jill Darling. Thank you. You may begin.

Jill Darling: Thank you, (Kelly). Good morning, and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications, and welcome to today's Physicians, Nurses and Allied Health Professionals Open Door Forum. Real quick from me, I have an announcement regarding the press.

This Open Door Forum is open to everyone, but if you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@CMS.HHS.gov. And I'll hand the call off to our co-chair, Dr. Gene Freund.

Dr. Eugene Freund: Hi, this is Gene Freund, and I want to welcome you to the physician fee schedule edition of the Physicians, Nurses and Allied Health Professionals Open Door Forum. And I hope you will all join me in thanking Mr. (Gift Tee), and his staff for all the work they've been doing on the physician fee schedule,

as well as our colleagues in other centers to - this is the result of a lot of annual work. A lot of people are going to be catching up on sleep. And without further ado, I'll turn it over to (Gift Tee).

(Gift Tee): Thanks, Gene. The hope is that we catch up on sleep, but as folks in the audience and others know, there's a lot of stuff that we put down along the way to get the fee schedule out. So, we're slowly picking those things up and trying to sleep at the same time.

In any case, good morning and good afternoon, everyone, and thank you for your patience as we work to put out the physician fee schedule for CY 2023. As Gene pointed out, lots and lots of policy development and just sheer conversations with you all that went into what we finalized.

We're going to cover a ton, but we're not going to cover all. So, I certainly encourage folks to continue to read the rule and reach out as necessary to discuss, allowing us some time to recover, catch our breath and sleep and so on, so forth.

But understanding, of course, that there is rulemaking that we engage in every year, and if there are things that need clarification or additional discussion, certainly feel free to reach out before we start to get into CY 2024 rulemaking, which is closer than we think.

And with all of that, just point out of course, that on November 2nd, 2022, CMS issued the final rule that includes updates and policy changes for

Medicare payments on the physician fee schedule and other Medicare Part B issues effective on or after January 1st, 2023.

This rule, as rules in the past and to come, one of several rules, reflects a broader administration-wide strategy to create a more equitable healthcare system that results in better accessibility, quality, affordability, and innovation. And with that, I'll turn it over to either Michael Soracoe, or Morgan Kitzmiller, to cover our PFS rate-setting conversion factor.

Michael Soracoe: Thank you, (Gift). This is Michael Soracoe. I'm going to discuss the conversion factor and a little bit about our clinical labor pricing update that's ongoing, and then I will turn it over to Morgan. All right. Well, there's always a lot of interest in our conversion factor.

As many of you on the call know, that is how we convert the relative value units used on the physician fee schedule into dollars. So, it's how we get our RVUs into dollars. There are a couple of things that go into the conversion factor each year. First of all, there is sometimes a statutory update factor. For 2023 that is 0%.

So, there's no statutory update factor. We also have a budget neutrality requirement that is in there by statute, which basically means that if total spending goes up, we have a negative adjustment to the conversion factor. If total spending goes down, we have a positive budget neutrality adjustment to the conversion factor.

For 2023, we have a negative 1.60 budget neutrality adjustment. That was largely due to the fact that we reviewed other E&M services in this rule, and there was additional spending on those other E&M services, and that resulted in a negative adjustment to the conversion factor, as I said, negative 1.60.

Then for 2023, we had one other thing that affected the conversion factor. Back last year, there was a bill passed called the Protecting Medicare and American Farmers from Sequester Cuts, that provided a one-year increase to the conversion factor of 3% for 2022.

So, for last year, for 2022, there was a one-year bump of 3%. That is due to expire at the end of 2022. So, we were required to calculate the conversion factor for 2023, with that provision no longer in effect. And so, that 3% is basically going away. So, after applying those adjustments, which are all required by law, our final 2023 PFS conversion factor came out at 33.06, $33.06, which was a decrease of $1.55 from the 2022 conversion factor of $34.61.

All right. The other thing I wanted to cover is the clinical labor update. So, as people on the call may know, we are in the middle of an ongoing clinical labor pricing update. We finalized a policy last year in 2022 rulemaking that we would update clinical labor pricing, and that we would do it over the course of four years. We would transition 2022, 2023, 2024, 2025.

So, this is the second year of that clinical labor pricing transition. In the rule, we updated a couple of different clinical labor types based on additional

information that we received, additional pricing, and wage data that we received as part of our public comment period.

So, there is - there are further details about which specific clinical labor rates were updated. It was, I think, about three or four of them were updated in response to additional information that we received. So, that will continue to go on for the next two years, for 2024 and 2025.

For those, we proceed through this four-year implementation of the clinical labor pricing update. I'll mention this, that we are - continue to be interested in additional information. So, if there is additional wage data out there, if people have information, we are always interested in additional, more accurate information that we use for pricing.

So, interested parties are encouraged to submit relevant information. We have an email box, PE price input update at CMS.HHS gov. That's in the rule if I went by that too quickly. But we are interested in additional information if anyone has it on clinical labor pricing or supplier equipment pricing, which we're also always working on.

So, as we said, always interested in additional information if others have to share on that. Now I will go ahead and turn it over to my colleague Morgan Kitzmiller, who will discuss the MEIs and the GPCIs.

Morgan Kitzmiller: Thanks, Michael. First up, the GPCIs or the Geographic Practice Cost Indices, for CY 2023, we updated the three GPCIs, the work, practice expense, and malpractice GPCIs, as statutorily required at least every three

years. The GPCIs measure resource cost differences among localities compared to the national average.

And we're also statutorily required to phase in the GPCI update over two years. So, the CY 2023 GPCIs are a 50-50 blend of last year's GPCI value and the updated 2023 GPCI value for each locality. This means that the GPCI update will be fully implemented in 2024 when the phase-in is complete.

And then regarding the Medicare Economic Index, or MEI, we finalized the proposed rebased and revised 2017-based MEI, with a few technical revisions to what we proposed regarding the methods, just based on some of the public comments that we received.

This new methodology allows for the use of data that is more reflective of current market conditions of physician ownership practices, rather than just reflecting costs for self-employed physicians. This also allows us to update the MEI more regularly since the data sources we use are updated and published on a regular basis.

We use the MEI in a couple of places, but in consideration of our ongoing efforts to update PFS rates with more predictability and transparency, and just to ensure payment stability, we proposed and finalized not to use the updated rebased revised MEI cost share rates in both PFS rate setting and the GPCIs for CY 2023.

Instead of going forward with using them, we solicited comments on the potential use of the rebased and revised MEI cost-share weights in future

rulemaking. And we just want to note that finalizing the use of the rebased and revised MEI cost-share weights for rate setting would not change overall spending on PFS services, but it would result in significant distributional changes to payments among PFS services across specialties and geographies. I think that's it for MEI, and I'll turn it over to the E&M team.

Anne Blackfield: Thanks, Morgan. My name is Anne Blackfield, and my colleague, Sarah Leipnik, and I will be summarizing finalized policies related to evaluation and management services. CMS finalized revaluation and coding and document changes for what are referred to as other E&M services.

These other E&M services include hospital inpatient, hospital observation, emergency department, nursing facility, home and residence services, and cognitive impairment assessments. Just as a reminder of the background, the American Medical Association's CPT editorial panel approved revisions for other E&M services effective January 1st, 2023.

So, in the CY 2023 PFS, we finalized adoption of many of the CPT changes. Our finalized policies include revisions to the other E&M code descriptors, which are new descriptor times (where appropriate), revised interpretive guidelines for medical decision-making, the elimination of the use of history and exam to determine code level, and the new policy allowing code level selection by either medical decision-making or time (except for a few families like emergency department visits, and cognitive impairment assessment, which are not timed services).

We also finalized adoption of CPT's consolidation of several E&M families, including a consolidation of the hospital inpatient and observation codes, and the home and residence visit codes. A couple of things to highlight. CMS is not adopting the 2023 CPT coding framework for prolonged other E&M visits.

We've finalized Medicare-specific coding for payment of other E&M prolonged services. The purpose of these Medicare-specific codes is to help provide oversight of prolonged service billing, and to reduce instances of duplicate - excuse me, duplicative billing.

We also finalized the retention of our longstanding policy that in most cases, a single practitioner may report only one E&M visit per patient per day. Our policy differs somewhat from 2023 CPT guidance that suggests that practitioners could bill more than one E&M visit in a single day.

And then finally, for the code families that were merged, we indicated in the rule that practitioners should generally continue to follow the same billing policies for these services, aside from changes to the CPT coding and descriptors.

However, we are going to monitor these codes closely and continue to review our billing policies in case future clarifications or rulemaking becomes necessary. And with that, I'll turn it over to Sarah for split/shared.

Sarah Leipnik: Thank you, Anne. Good afternoon, and good morning. My name is Sarah Leipnik, and I'm going to be discussing the policies regarding split/shared

services. For CY 2023, we finalized a year-long delay of the split/shared visits policy we established in rulemaking for CY 2022.

This policy determines which professional should bill for a shared visit by defining the substantive portion of the service as more than half of the total time. Therefore, for CY 2023, as in CY 2022, the substantive portion of the visit is comprised of any of the following elements. History, performing a physical exam, medical decision-making, spending time, more than half of the total time spent by the practitioner who bills the visit.

As finalized, clinicians who furnish split/shared services, will continue to have a choice of history or physical exam or medical decision-making, or more than half of the total time of the total practitioner time spent to define the substantive portion instead of using total time to determine the substantive portion until CY 2024. Now, I'm going to turn it back over to (Gift Tee).

(Gift Tee): Thank you, Sarah. Now, I'll cover some of our policies in our behavioral health space. So, a lot of current needs among Medicare beneficiaries for improved access to behavioral health services. We have considered regulatory revisions that may help to reduce existing barriers and make greater use of the services of behavioral health professionals, such as Licensed Professional Counselors and Licensed Marriage and Family Therapists.

We finalized a proposal to add an exception to the direct supervision requirement under our incident to regulation to allow behavioral health services to be provided under the general supervision of a physician or non-physician practitioner, rather than under direct supervision when these

services or supplies are provided by auxiliary personnel, such as the LPCs and LMFTs I called out, incident to the services of a physician or a non-physician practitioner.

We also clarified in this rule that any service furnished primarily for diagnosis and treatment of a mental health or substance use disorder, can be furnished by auxiliary personnel under the general supervision of a physician or NPP, who is authorized to furnish and bill for service provided incident to their own professional services.

We believe that this change will facilitate access and extend the reach of behavioral health services. We also indicated in the rule that we intend to address payments for new prescribed caregiver behavioral management training in CY 2024 rulemaking. We also - in consideration of our behavioral health strategy, thought about some other changes that we could make in this space.

In the CY 2017 and 2018 PFS rulemaking, we received comments that initiating visit services for Behavioral Health Integration, BHI, should include in-depth psychological evaluation delivered by clinical psychologists, and that CMS should consider allowing professionals who are not eligible to report the approved initiating visit codes to Medicare, to serve as a primary hub for BHI services.

Considering the increased need for mental health services and the feedback we received, we finalized a proposal to create a new general BHI code, which describes the service personally performed by clinical psychologists or

clinical social workers to account for monthly care integration where the mental health service is furnished by a CP or CSW, are serving as the focal point of care integration.

We're also finalizing a proposal to allow psychiatric diagnostic evaluation to serve as an initiating visit for the new general BHI service. And with that, I'll turn it over to my colleague, Erick Carrera, to cover chronic pain management.

Erick Carrera: Hello. Thank you, (Gift). We're pleased to share our finalized policies for new chronic pain management and treatment coding and payment effective January 1st, 2023. We made the effective treatment of pain a key goal in our CMS behavioral health strategy.

We understand that treatment of pain in older adults and people with disabilities, including those enrolled in Medicare, is most successful when a focused multimodal approach to care is utilized. We have finalized new HCPCS codes and valuations that we believe may facilitate payment for medically necessary services, may prompt more practitioners to welcome Medicare beneficiaries with chronic pain into their practices, and may encourage practitioners already treating Medicare beneficiaries who have pain, to spend the necessary time to help manage their condition within a trusting, supportive, and ongoing care partnership.

The finalized HCPCS codes G3002 and G3003, include a bundle of services furnished during the months that we believe to be the starting point for holistic chronic pain management. We have finalized HCPCS code *(G)*3002 to

include the following service elements, diagnosis, assessment and monitoring, administration of a validated pain rating scale or tool, development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes, overall treatment management, facilitation, and coordination of any necessary behavioral health treatment, medication management, pain and health literacy counseling, any necessary chronic pain-related crisis care, and ongoing communication and coordination between relevant practitioners furnishing care, for example, physical therapy and occupational therapy, complementary and integrative care approaches, and community-based care as appropriate.

We welcomed and received many constructive comments from clinicians, other providers, advocacy and professional groups, people with chronic pain and their caregivers, as to nearly all aspects of the proposed policies. We thank you.

And as a result of the feedback, we made several clarifications, finalized policies with modifications for additional flexibilities, and otherwise finalized policies as we proposed them in the NPRM. I'll turn it over to Patrick Sartini.

Patrick Sartini: Thank you. So, for CY 2023, we are finalizing a number of policies related to Medicare telehealth services and other services involving communications technology, including we are finalizing that codes which are temporarily available as telehealth services for the PHE, we are finalizing that those services continue to be available for a period of 151 days following the end of the PHE, to align with other telehealth-related flexibilities implemented by the CAA of 2022.

We are making many of these temporarily available services available through 2023 on a category three basis, which will allow for additional time for the collection of data that could support the eventual inclusion of these services as permanent additions to the Medicare telehealth list.

For 2023, we are also adding to the telehealth list as permanent additions, new codes which describe prolonged services and chronic pain management. CAA 2022 delays in-person visit requirements for mental health services furnished via telehealth until 152 days after the end of the PHE.

And we are clarifying in this rule that for beneficiaries who began receiving these mental health services via telehealth during this period, PHE plus 151 days, the initial in-person visit requirements will be considered to have been met.

We finalized that for Medicare telehealth services, we will continue to maintain payment with the place of service code had the service been furnished in-person, and this will allow payments to continue to be made at the non-facility-based rate for Medicare telehealth services through the latter of the end of CY 2023, or the end of the calendar year in which the PHE ends.

As a reminder, for the duration of the PHE, to limited infection exposure, we revised the definition of direct supervision to include virtual availability of the supervising physician or practitioner using interactive audio, video real-time communications technology.

In the 2022 and 2023 final rules, we solicited comments on whether this revised definition should continue following the PHE, and if so, in what circumstances. This policy will continue through the end of the year in which the PHE ends. And with that, I will turn it over to Pam West, who will discuss audiologist services.

Pam West: Thank you, Patrick. I'm Pam West, and I will now talk about the provision for audiologist services. For calendar year 2023, CMS finalized the policy to allow beneficiaries direct access to an audiologist without an order from a physician or non-physician practitioner for non-acute hearing conditions.

The finalized policy will use a new modifier, that is modifier AB, instead of using a new HCPCS G code as we proposed, because we were persuaded by the commenters that a modifier would allow for better accuracy in reporting, and reduce burden for audiologists.

This direct access policy will allow beneficiaries to receive care for non-acute hearing assessments that are unrelated to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids.

And as we established in the regulation at section 410.32 (a)(4) of the Code of Federal Regulations, audiologists may personally furnish diagnostic audiology tests for a patient, once per patient, for a 12-month period without an order from the treating physician, or non-physician practitioner.

The modification in our finalized policy requires multiple changes to our claims processing systems, which will take some time to fully operationalize,

possibly mid-year 2023. Until such time, audiologists may elect to used modifier AB, along with a finalized list of 36 codes for dates of service on and after January 1st, 2023.

Alternatively, this same list of codes, along with the other codes for balance assessments, are not affected by modifier AB policy or the 12-month frequency limitation when medically necessary diagnostic tests, including those furnished by audiologists, are ordered by a physician or a non-physician practitioner. And now I'll turn it over to Anne Blackfield.

Anne Blackfield: Thanks, Pam. Hello, again. This is Anne Blackfield. I'm going to provide information about our dental policy in the final rule. So, just to frame this up. Medicare currently pays for dental services in a limited number of circumstances, namely when that service is an integral part of the treatment for a primary medical condition.

So, some examples include, reconstruction of the jaw following fracture or injury, tooth extraction done in preparation for radiation treatment for cancer in the jaw, or oral exams preceding kidney transplantations. In the CY 2023 final rule, we finalized our proposal to clarify and codify certain aspects of the current Medicare fee-for-service dental payment policy, in particular payment for dental services when that service is an integral part of a specific treatment of a beneficiary's primary medical condition.

So, basically the - including the examples I just provided of, you know, tooth extraction prior to radiation treatment of the jaw and things like that. We also finalized effective CY 2023, our proposal for Medicare Parts A and B

payment for certain dental services such as dental exams and necessary treatments performed prior to, or contemporaneously with, organ transplants, cardiac valve replacements, and valvuloplasty procedures.

We believe that these are examples of where some dental services are inextricably linked to the clinical success of the covered medical service. And again, medical service in this case being the organ transplant, cardiac valve replacement, or valvuloplasty procedure.

We are also finalizing payment for dental exams and necessary treatments prior to, or contemporaneously with, the treatment for head and neck cancers. This policy will be effective starting in CY 2024. Additionally, we are finalizing a process for CY 2023 that will allow CMS to review and consider public recommendations for Medicare payment for dental services in other clinical scenarios.

A few notes. At this time, we are continuing to contractor price these services. This means that the MACs will continue to set prices for these services, as they do currently. In response to comments, we also codified that payments will be allowed for inextricably linked dental services furnished in both the inpatient and outpatient settings.

We also received many comments on the possible relationship between dental services and other medically-covered treatments, such as immunosuppressive treatments and joint replacements. While we are not finalizing a policy related to these treatments at this time, we are continuing to review the evidence we have received.

We will also use the process that I just mentioned, the public review process, to look at the evidence supplied for these treatments and other things that were supplied during the CY 2022 rule period. And finally, we are working to address commenters' thoughtful feedback and questions regarding the operational aspects of billing and claims processing for these services.

We'll continue to work with our MACs and encourage continued feedback from interested parties to help identify concerns or questions regarding dental claim submission and processing. And with that, I'll turn it over to Zehra Hussain.

Zehra Hussain: Thanks, Anne. Good afternoon, everyone. My name is Zehra Hussain, and I will be discussing skin substitute policies under the PFS final year. CMS proposed several changes to the policies for skin substitute products to streamline the coding, billing, and payment rules, and to establish consistency with these products across various settings.

Specifically, CMS proposed to change the terminology of skin substitutes to wound care management products, and to treat and pay for these products as incident to supplies under the PFS, beginning on January 1st, 2024.

After reviewing comments on the proposals, we understand that it would be beneficial to provide interested parties more opportunities to comment on the specific details of changes in terminology, coding, and payment mechanisms prior to finalizing a specific date when the transition to a more appropriate and consistent payment and coding for these products will be completed.

We plan to conduct a virtual town hall in early CY 2023 with interested parties to address commenters' concerns, as well as discuss potential approaches to the methodology for payment of skin substitute products under the PFS.

We will take into account the comments we received in response to CY 2023 rulemaking and feedback received in association with the town hall in order to strengthen proposed policies for skin substitutes in future rulemaking. And with that, I will hand it over to Laura Kennedy.

Laura Kennedy: Thank you. I'll be talking about the discarded drug refund section 90004 of the Infrastructure Investment and Jobs Act amended section 1847A of the act, adding provisions that require manufacturers to provide refunds to CMS for certain discarded amounts from drugs prepared from refundable, single-dose containers, single-use package drugs.

The refund amount of the discarded drug that exceeds an applicable percentage, which is required to be at least 10% of the total allowed charges for the drug is given, and in a given calendar quarter will be calculated. We've proposed policies to implement section 90004 of the Infrastructure Act in the physician fee schedule.

We're finalizing proposed policies for the definition of which drugs are subject to refunds and their exclusions, an applicable percentage for certain drugs reconstituted in hydrogel, how discarded amounts of drugs are

determined, a refund calculation methodology, a dispute resolution process, and enforcement provisions.

However, we are not finalizing that the initial reports will be sent out no later than October 1 of 2023. We will send out preliminary informational reports to manufacturers for the first two quarters of 2023, no later than December 31st of 2023. And we will revisit the date of the initial report in future rulemaking. I'll pass it to Rachel next. Thank you.

Rachel Radzyner: Thanks, Laura. This is Rachel Radzyner to discuss the Part B preventive vaccine administration services. In this final rule, we finalized refinements to the payment amount for Medicare Part B preventive vaccine administration.

Last year, we announced the uniform payment of $30 for the administration of a flu, pneumococcal, or Hepatitis B vaccine, and $40 for the administration of the COVID-19 vaccine. And we also discussed an additional payment of $35.50 for the administration of in-home COVID-19 vaccinations.

We've continued that in-home additional payment for CY 2023. And we also finalized our policy to annually update those payment amounts based upon the increase in the Medicare Economic Index or MEI, and to use the Geographic Adjustment Factor, or GAF, to adjust for geographic locality based upon the fee schedule area where the preventive vaccine is administered.

With the CY23 MEI update of 3.8%, the payment amount for flu, pneumococcal and hepatitis B vaccine administration for CY '23 is $31.14. And the payment amount for a COVID-19 vaccine administration at this time

is $41.52. The additional in-home payment amount for COVID-19 vaccine administration is $36.85.

In the final rule, we also clarified our policies to reflect that certain policies' termination is aligned with when the HHS Secretary will end the EUA declaration for drugs and biologics with respect to COVID-19, rather than when the PHE ends. So, the EUA declaration will be the endpoint for that.

This includes payment for the administration of the COVID-19 vaccine, which will align with the payments for vaccine administration of the other Part B vaccines once the EUA declaration ends. Finally, since last year's final rule, a monoclonal antibody product for preexposure prophylaxis prevention of COVID-19 was granted an EUA, and we finalized that we will pay for this type of product and its administration under the Part B vaccine benefit, even after the EUA is terminated.

So, that is a permanent addition to the benefit. And that's all we have for Part B vaccines today, and I'll pass it to (Lucy).

(Lucy Bertocci): Thanks. I'm going to be talking through some of the finalized policies for the Medicare shared savings program. First, we have the Advanced Investment Payments or AIP. We have finalized the Advanced Investment Payments that will provide upfront payments for new low-revenue ACOs that can be used to invest in provider infrastructure staffing and social determinants of health.

The advanced investment payments will include a 250,000 one-time upfront payment, and then quarterly payments based on beneficiary assignment. These payments will be recouped through the shared savings earned by the ACOs.

For participation options, beginning with performance year 2024, ACOs that are inexperienced with performance-based risk may participate in one five-year agreement that is one-sided only. And then in the second agreement period, the ACO would progress along the glide paths, giving an ACO up to seven years of shared savings only before they have to take on risk.

ACOs currently participating in level A or B of the basic track will have the option to elect to continue in the one-sided only for the remainder of their agreement. And then for agreement periods beginning on January 1, 2024, we've removed the limitation on the number of agreement periods an ACO can participate in level E of the basic track.

So, participation in the enhanced track will be optional. On the financial benchmarks, we're modifying the methodology to strengthen financial incentives for long-term participation by reducing the impact of the ACOs' performance and market penetration on their benchmarks, and to support the business case for ACOs serving high-risk and high dually-eligible populations.

So, we're finalizing changes to the benchmarking policies that include updating benchmarks to include a one-third accountable care perspective trend, incorporating a prior savings adjustment to address the ratchet effects,

reducing negative regional adjustments, and improving the ACO risk adjustment cap.

We're also modifying the calculation of the regional fee-for-service expenditures to align calculations with the ACOs' chosen assignment methodology, which eliminates a bias that was in the existing calculations. We're also expanding opportunities for certain low-revenue ACOs participating in the basic track to share in savings, even if they don't meet the minimum savings rate, to allow for investments in care redesign and quality improvement activities for less capitalized ACOs.

For quality, we're finalizing policies related to the quality reporting and quality performance requirements that are designed to support the transition of ACOs to all-payer quality measure reporting. So, this includes establishing a health equity adjustment to an ACO's quality performance category score for ACOs reporting all-payer eCQMs, MIPS CQMS, that will provide incentives for high-quality measure performance for ACOs serving high deprivation areas or low-income subsidy or dually-eligible populations, to recognize high-quality performance by ACOs with underserved populations.

We're also incorporating a sliding scale methodology for ACOs that meet minimum quality reporting and performance requirements, but fall below the level of performance required to receive the maximum sharing rate for their track in order to avoid the sort of all-or-nothing approach to shared savings.

And we've also revised the approach for determining shared losses for ACOs participating in the enhanced track. And then lastly, on administrative burden,

we've finalized some changes here, including modifying the requirement for ACOs to provide beneficiary notice prior to, or at the first primary care service to once per agreement period instead of annually, with beneficiary engagement interaction taking place within 180 days after the beneficiary notice is provided.

We're also revising the requirements related to marketing material review, the SNF three-day rule waiver application and data sharing requirements. And from here, I can pass it over to Kati Moore.

Kati Moore: Great. Thanks, (Lucy), and good afternoon, good morning, everybody. I know we've thrown a lot of information at you really quickly, so I will try and get through my quality payment program updates quickly as well so we can leave time for any questions.

So, since we only have a little bit of time, I really want to make sure everybody is aware that we have a QPP overview webinar scheduled for next Wednesday, November 16th, where we'll have all of our different subject-matter experts on to answer questions, and really do a deep dive into our specific quality payment program final policies that were in the PFS.

So, definitely encourage folks to register for that event and join us next week. And then, if you haven't seen already, we have on qpp.cms.gov, on our resource library, we have a zip file with all of our QPP-specific final rule resources.

We have an overview factsheet, a really great policy comparison table that shows the changes from 2022 to 2023, and then everything about MVP policies, as well as a bunch of frequently asked questions that we've put out there.

So, encourage everybody to check all of that information, but I will go ahead and kind of just try and hit the highlights here real quick for you. And so, as we're looking to the future of QPP, we're really frankly, committed to promoting more meaningful participation for clinicians and ensuring that we're not just creating policies for the sake of policy development, but that we're really continuing to drive the program toward value, and ultimately the goal of improving health outcomes for all of our patients.

And to do this, so we've really focused on - in this - in the 2023 final rule policies, continuing to develop new MVPs, refining our MVP subgroup participation option that I know we've had a lot of questions about recently, and then just some updates to quality measures and improvement activities, inventories, and then a couple of changes to help reduce burden to facilitate participation into APM.

So, I'll go into a little bit more detail when we have some time. So, for MVPs, so if you aren't familiar with this term, it's MIPS, so the Merit-Based Incentive Payment System Value Pathways. So, we refer to them as MVPs. We're continuing to develop new ones every year.

So, we have finalized five new MVPs, and then we revised seven previously established MVPs for reporting beginning with 2023. So, we're really excited

about these new developments and looking forward to engaging with clinicians as they start participating through MVPs next year.

So, we've also made an update or calculating and scoring administrative claims measures, so for quality and costs that the affiliated group Tax Identification Number, TIN level if choosing to report it as a subgroup.

And then just another kind of logistical change is using our initial 12-month segment of our 24 months MIPS determination period to determine eligibility for clinicians that intend to participate and register as a subgroup. That way, we don't wait till the end of the 24-month determination period, because then you would've missed the subgroup registration window.

So, basing that on the first segment. And then shifting gears a little bit to traditional MIPS, so we really tried to limit the changes to policies within traditional MIPS for 2023. And the goal of that is to provide clinicians with some additional continuity and consistency while you gain familiarity with MVPs.

So, this is really the direction that the program is heading in the future, as we've talked about on a lot of different events. But - so some changes that (unintelligible). So, we're continuing to use the mean final score for the 2017 performance year to establish our performance threshold for 2023.

So, that is not changing. So, our threshold will be 75 points for 2023. We're increasing the data completeness threshold to 75%, but not until 2024 and 2025 performance years. We will be retaining the 70% data completeness

threshold for 2023. And then we're updating the measure reporting requirements for our promoting interoperability performance category.

And then the - we've just made a number of other changes related to our quality measures and improvement activities inventory, expanding some definitions and reducing the inventory of quality measures from 200 to 198. So, really removing those topped-out measures and adding a few new ones.

So, encourage folks to check out our tables and our resources to get all of the additional details on all of the specifics there. And then lastly, just wanted to highlight a couple of policies related to our advanced APM track of quality payment program.

So, we have modified how the 50 eligible clinician limit is applied to medical home models, make it easier to implement and more equitable. And we're also removing the 2024 expiration of the 8% minimum on the generally applicable nominal risk standard for advanced APMs, and just making that 8% minimum permanent. So, it won't expire in 2024. And that is it in a nutshell for QPP. So, I think Jill, I'll turn it back over to you for QA.

Jill Darling: Yes. Thanks, Kati. And thank you to all of our speakers today. Greatly appreciate you taking the time out. And (Kelly), we will open the lines for Q&A, please.

Coordinator: All right, sounds great. So, if you would like to ask a question, please press Star 1, unmute your phone, and record your name. If you would like to withdraw your question, you can press Star 2. And again, to ask a question,

press Star 1. And our first question is going to come from Amy Maverick. Amy, your line is open.

Amy Maverick: Thank you. Thank you so much for clarifying the admissions that span of midnight, so spanning the transition of two calendar dates. My question though has to do with, we are directed to bill the admission code, the initial visit code on the calendar date the encounter began.

Oftentimes, as hospitalist physicians, we find that we start to provide services to that patient and have a face-to-face encounter before midnight. The service continues uninterrupted through midnight into the next calendar day, but we may not get that admission order in until the post-midnight day because we need to go in and evaluate the patient before we're able to put in that inpatient or observation order.

So, my question is, what do we do with billing if we start seeing the patient before midnight, but we don't get the admission order, whether that's observation or inpatient, in until after midnight? Will Medicare pay for that CPT code that's submitted before the admission order is technically submitted into the hospital system?

Anne Blackfield: Hi, this is Anne Blackfield. I'm guessing this was a question about the hospital inpatient coding updates, just clarifying, just to confirm?

Amy Maverick: Yes.

Anne Blackfield: Okay. So, I think for now, I would actually - sorry to punt a little bit, but I would actually talk to your MACs just to get any kind of clarification, because other ones we were looking at the actual claims. I'm going to stop there.

We'll take it back and see if there's any like additional discussion we need to have with the MACs, so like any additional clarifications we can offer for - but for now, I would just talk to your MACs about how to like accurately reflect the date on the claims.

Amy Maverick: Okay. Thank you.

Coordinator: Your next question comes from Amanda Lamar. Amanda, your line is open.

Amanda Lamar: Hi, thank you. My question was regarding the same-day admission and discharge codes in the eight to 24-hour rule. For physician CPT billing accuracy, would we bill based on the time between the physician's face-to-face admission encounter and the discharge encounter, or based on the number of hours the patient is in the hospital?

Anne Blackfield: Hi. This is Anne Blackfield again, and I'm going to give you another punt to that. I apologize. So, this - the eight to 24-hour rule isn't a new policy. We were just sort of codifying it. So, ideally, this shouldn't be a new issue. I say that with the understanding that, you know, I'm not the one putting in the bill.

So, again, right now, I would say talk to your MACs for any kind of additional clarification, because the idea was that people would continue to sort of bill as they had been. But again, we're - as we indicated in the final rule, we're

definitely like reviewing this to see what kind of additional guidance we can give. So, I can't answer you concretely right now, but I do encourage you to talk to your MAC.

Amanda Lamar: Okay. And then I had one additional question If I could. For shared critical care visits, would we need to add the FS modifier if billing is going out under the NPP?

Anne Blackfield: That, I have to defer to Sarah, or we might need to take that back.

Sarah Leipnik: Yes, or Erick, do you know offhand, or should we take that back?

Erick Carrera: Let's take that back.

Sarah Leipnik: Okay. Jill, do we have an email to send questions?

Jill Darling: Yes. You can email partnership@CMS.HHS.gov. It's on the agenda as well.

Amanda Lamar: Okay. Thank you so much.

Jill Darling: You're welcome.

Sarah Leipnik: Thank you.

Coordinator: Our next question comes from (Kate Gilliard). Kate, your line is open.

(Kate Gilliard): Thank you. My question is regarding the remote therapeutic monitoring codes. CMS pretty clearly states in the final rule that these codes are subject to general supervision, but it appeared that that followed a discussion on incident to billing.

So, I just wanted to confirm that that statement doesn't modify other regulations that speak to supervision of specific provider types, particularly physical therapist assistants in private practice who are required to be under direct supervision for all services under 42 CFR 410. Thanks.

(Gift Tee): Hey, this is (Gift). Great question. If you wouldn't mind submitting, we will clarify. But in that discussion, we were truly talking about the RTM versus other services and the construct that exists for those services under a different consideration. So, you submit the question. We'll try to provide more clarification.

(Kate Gilliard): All right. I will. Thank you.

Coordinator: And our next question comes from (Karen). (Karen), your line is open.

(Karen): Thank you. And thank you again for the clarification on many of these topics, I would just like to ask for additional clarification on split/shared visits in the hospital setting. The definition - beginning in 2023, the definition for those codes will be medically appropriate history and/or exam.

So, if the MD, for example, does a couple of organ system exams and says that's what was medically appropriate for this patient, then depending on the

MVP's documentation, that could be billed as a 99223, for example, under the MD. Is that correct?

Sarah Leipnik: Are you asking for the level of the visit? I'm sorry, I'm just not ...

(Karen): No, no, I'm sorry. Not for the level of the visit, but just, it can be billed at the levels supported by the NPP's documentation in that case.

Sarah Leipnik: If the NPP is providing that element as a substantive portion?

(Karen): I'm sorry. Let me switch the way I ask the question. If - could the MD's documentation of a very small exam, if she, or he feels that is medically appropriate, could that be considered a substantive portion of a visit?

Sarah Leipnik: Do you mind sending that in the mailbox? Oh, sorry. Go ahead.

Anne Blackfield: And I actually - yes, I do encourage you to actually resubmit this in the mailbox. I think - I imagine the question is coming from the fact that, you know, hospital inpatient observation descriptors changed so that they no longer go into such detail about the history and the exam.

It's now been consolidated into, they have to perform a medically appropriate exam or history or exam, correct. And so, that could be - there could be some variability to how much work involves. Is that fair?

Sarah Leipnik: Yes. And given the proposed delay of the implementation of the substantive portion, like the current policy remains in place. So, when an E&M visit

requires a medically appropriate history and/or physical exam, in accordance with the code descriptor, then the service could be - then the service elements can qualify as a substantive portion when performed.

(Karen): Okay. All right. Thank you.

Jill Darling: Hi (Kelly). This is Jill. How many more questions do we have in the queue?

Coordinator: We have one.

Jill Darling: Okay, thank you. We'll take that as our last question, please.

Coordinator: All right. Our last question is going to come from (Sheila) (unintelligible). (Sheila), your line is open.

(Sheila): Hi. Yes. My question is actually very similar or if not the same to the question that was just asked. And it's just very confusing to try to educate providers on what they should be documenting in billing. So, the rules for inpatient services have changed that those services are either going to be determined by medical decision-making or time.

Yet when they're working in a split/shared service, they could potentially document a medically appropriate history and exam, which might be a detailed exam. It doesn't have to be comprehensive. If that's deemed medically appropriate, then they could bill a high-level service, and the medical decision-making isn't even taken into account.

It's very confusing to try to educate that. So, I think what people are concerned about or confused about is moving forward, how are we educating our providers regarding split/shared? It's a complete 180 from what we're educating them in the new 2023 rule when choosing an E&M service based on medical decision-making or time.

Sarah Leipnik: Thank you for the question. Oh, (Gift), go ahead.

(Gift Tee): I was just going to say, we hear what you're saying, and certainly, it sounds like there could be some conversation in our future. So, reach out, email us and, you know, if we could have discussions that could be helpful in how we are thinking about the policy and our concerns and why we are - continue to discuss this, maybe that helps straighten things out relative to what you're seeing as you all work back, you furnish those services in your workflow. So, definitely reach out and we'll be willing to talk some more.

(Sheila): Yes. I mean, I think the problem is, we're making - you know, why work at a very large enterprise in Boston, and we're trying to roll out education to thousands of providers, and we can't give a clear, consistent message, and it's very frustrating.

(Gift Tee): No, completely hear what you're saying. So, definitely reach out, send an email and, you know, if there's opportunity to talk, we welcome it.

(Sheila): Okay. And where should the email be sent?

(Gift Tee): Jill, what's our email box again? I'm sorry.

Jill Darling: Oh, no worries. It's partnership@cms.hhs.gov.

(Sheila): Thank you.

Jill Darling: You're welcome. All right, everyone. Well, that was our last question, and we appreciate you dialing in for today's physician's call. Thank you again for your time and have a wonderful day.

Coordinator: That concludes today's call. Thank you for participating. You may disconnect at this time. Speakers, please allow for a moment of silence and stand by for post-conference.

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