



MEDICAL
REVENUE CYCLE
SPECIALISTS

Illinois Public Health Association

Encore Presentation of CMS 2024 Final Rule Physician Impact

May 8, 2024

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Your Speaker



Kem Tolliver, FACMPE, CPC, CMOM
CEO of
Medical Revenue Cycle Specialists

Professional Experience Highlights:

- Author of "Revenue Cycle Management: Don't Get Lost in the Financial Maze" published by MGMA®
- Author of "Advanced Strategy for Medical Practice Leaders – Financial Management Edition" published by MGMA®
- MGMA® distinctions in, "Better Performing Practice" distinctions in Accounts Receivable & Collections
- Prior Chair of Government Affairs Committee and member at large for Board of Directors of MD MGMA
- Maryland General Assembly expert testimony supplier on healthcare and financial legislation
- Adjunct Professor of Revenue Cycle at Catonsville Community College
- Co-Host of RevDive Podcast hosted by Slice of Healthcare Media
- National Presenter and Educational on Revenue Cycle Management, Practice Management and Coding

Education & Certifications:

- Dual B.S. degrees in Healthcare Administration (Summa Cum Laude) & Organizational Management (Magna Cum Laude)
- Fellow American College of Medical Practice Executive (FACMPE), Certified Professional Coder (CPC), Certified Medical Office Manager (CMOM)

Professional Affiliations:

- Faculty Member of Practice Management Institute and Member of CMOM Certification Program Committee
- Past President of Prince George's County, Maryland chapter of AAPC
- Co-founder of Prince George's County Practice Manager's Association
- Serves on the Novitas JL Carrier LCD Advisory Committee
- Serves on the MGMA Evaluation and Management Strategy Committee
- Served on the Board of Directors for Laurel Regional Hospital from 2017-2018
- Served as a Mentor for the Prince George's County Public School's 2018 PTECH Health Innovation Program
- Served on the Totally Linking Care-Maryland Advisory Council

Awards & Recognitions:

- State of Maryland Governor's Volunteer Service Certificate for 2015-2018
- Nexus Health, Fort Washington Medical Center nominated her for the 2016 Community Health Award
- MD MGMA's 2016 Outstanding Service Award
- Heart to Hand, Inc. 2019 Heart of Gold Award for 501(c)(3) community-based public health medical practice leadership

Learning Objectives

Review key payment updates ushered in with the 2024 CMS Final Rule

Objective 1

Outline key coding and CMS program guidelines impacting 2024 compliance

Objective 2

Analyze strategies to prepare for 2024 success

Objective 3

Terms to Know

ACOs	Accountable Care Organizations		HCPCS	Healthcare Common Procedure Coding System
APMs	Alternative Payment Model		MDM	Medical Decision Making
APPs	APM Performance Pathway		MFTs	Marriage and Family Therapists
CAA	Consolidated Appropriations Act		MHCs	Mental Health Counselors
CDC	Centers for Disease Control and Prevention		MIPS	Merit based Incentive Payment System
CEHRT	Certified Electronic Health Record (EHR) Technology		MSSP	Medicare Shared Savings Program
CHI	Community Health Integration		MVPs	MIPS Value Pathways
CLFS	Clinical Laboratory Fee Schedule		NPP	Non-Physician Practitioner
CMS	Centers for Medicare and Medicaid Services		OPTs	Opioid Treatment Programs
CQM	Clinical Quality Measures		PFS	Physician Fee Schedule
DEA	Drug Enforcement Administration		PIN	Principal Illness Navigation
DME	Durable Medical Equipment		QP	Qualifying APM Participant
DSMT	Diabetes Self Management Training		RHCs	Rural Health Clinics
E/M	Evaluation and Management		RVUs	Relative Value Units
FFS	Fee For Service		SAMSA	Substance Abuse and Mental Health Services Administration
FQHCs	Federally Qualified Health Centers		SDOH	Social Determinants of Health

Medicare Physician Fee Schedule (MPFS)

CMS Final Rule Publication



The Centers for Medicare and Medicaid Services (CMS) seeks public comments on proposed rules prior to those rules being finalized. Physicians and the healthcare community alike, are encouraged to actively participate in rule setting to foster an inclusive regulatory environment.

- The **CY 2024 Medicare Physician Fee Schedule (PFS) Proposed Rule** was released by the **Centers for Medicare & Medicaid Services (CMS)** on July 13, 2023.
- The **Final Rule** was released on November 2, 2023, and is effective beginning January 1, 2024.

Annual Business Planning should include proposals and final rules outlined by CMS, OIG, ONC, OCR and other key governing entities.

Medicare Physician Fee Schedule (MPFS) Conversion Factor (CF)

The MPFS is the payment structure used by CMS to pay physicians and eligible healthcare practitioners for services and supplies. The Conversion Factor is the base rate used for calculating that reimbursement. The CF is adjusted annually for budget-neutrality.

Calendar Year		Conversion Factor
2019	↓	\$36.0391
2020	↑	\$36.0896
2021	↓	\$34.8931
2022	↓	\$34.6062
2023	↓	\$33.89
2024	↓	32.7442

Proposed CF rate for 2023 (33.08)
Finalized CF Rate 2023 (33.89)

Proposed CF Rate 2024 (32.75)
Finalized CF Rate 2024 (32.74)

The CY 2024 MPFS conversion factor reflects a decrease of \$1.15 (or 3.4%).

National Government Services

Medicare Administrative Contractor (MAC)

Fee Schedule Access

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FEE SCHEDULE LOOKUP

Fee Schedule Lookup

To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select **Search**.

Note: If your search does not display the fee schedule or effective date (range) you enter, access the CMS website to view and download [National Fee Schedules](#).

Select a Fee Schedule: *

- Select Fee Schedule--
- ASC Fees
- Ambulance
- Anesthesia Conversion Factor
- CP/CSW
- Flu/PPV/Hepatitis
- Home Infusion Therapy Services (HITS)
- Medicare Physician Fee Schedule Pricing**
- Opioid Treatment Program (OTP)

National Government Services Medicare Administrative Contractor (MAC) Fee Schedule Access

Fee Schedule Lookup

To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select **Search**.

Note: If your search does not display the fee schedule or effective date (range) you enter, access the CMS website to view and download [National Fee Schedules](#).

Select a Fee Schedule: *

Medicare Physician Fee Schedule Pricing

Result Type: *

Full Fee Schedule

Specific To Fee Code

Date of Service: *

05/01/2024



Procedure Code: *

99213

Region: *

Illinois (area 12)

Search

National Government Services Medicare Administrative Contractor (MAC) Fee Schedule Access

Locality Lookup

State: *

Illinois

County: *

-Select-

-Select-

Adams

Alexander

Bond

Boone

Brown

Bureau

Calhoun

Carroll

Cass

Champaign

Christian

Clark

Clay

Clinton

Coles

Cook

Crawford

Cumberland

De Kalb

Fee Schedule Assistance

The [fee schedule assistance](#) page provides access to

Radiopharmaceutical Reimbursement

The [Radiopharmaceutical Reimbursement](#) page provides access to radiopharmaceuticals.

National Fee Schedules

Access the [CMS](#) website to view and download the following national fee schedules.



National Government Services Medicare Administrative Contractor (MAC) Fee Schedule Access

Fee Schedule Lookup

To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select **Search**.

Note: If your search does not display the fee schedule or effective date (range) you enter, access the CMS website to view and download [National Fee Schedules](#).

Select a Fee Schedule: *

Medicare Physician Fee Schedule Pricing

Result Type: *

Full Fee Schedule

Specific To Fee Code

Date of Service: *

05/01/2024

Procedure Code: *

99213

Region: *

Illinois (area 12)

Search

Insurance Fee Schedule Analysis

Analyzing your fee schedule helps to identify inconsistencies in payment, postings, underpayment trends and non-compliance of contract terms. Doing so also is the foundation for trending data that may be used for financial decision making.

CPT Codes	Description	Charge	Medicare	Payer #1	Volume	Value Based ADJ + or -
99203	NP L3	145.00	117.01	125.00	400	
99204	NP L4	220.00	177.92	Not listed	300	
99205	NP L5	250.00	223.39	239.00	2500	
99213	Estab L3	100.00	80.46	70.00	750	
99214	Estab L4	125.00	117.58	119.00	700	
99215	Estab L5	150.00	157.40	160.00	1200	
93000	EKG w/Interp	50.00	18.65	25.00	500	
94010	Spiro w/TC mod	50.00	30.06	60.00	1000	
99354	Prolonged / 1 st hr	160.00	139.94	32.00	125	
99490	CCM 20 min	75.00	44.88	38.00	89	
99491	CCM 30 in	85.00	88.83	100.00	5	
99495	TCM Med complex	200.00	177.78	150.00	275	
99496	TCM High complex	300.00	250.82	275.00	2	

Charge Description Master

CPT Codes	Description	Charge
99203	NP L3	145.00
99204	NP L4	220.00
99205	NP L5	250.00
99213	Estab L3	100.00
99214	Estab L4	125.00
99215	Estab L5	150.00
93000	EKG w/Interp	50.00
94010	Spiro w/TC mod	50.00
99354	Prolonged / 1 st hr	160.00
99490	CCM 20 min	75.00
99491	CCM 30 in	120.00
99495	TCM Med complex	200.00
99496	TCM High complex	300.00

Gross Charge List

- Created by the Clinic / Specialty
- Health Clinic selects CPT/HCPCS Codes
- Health Clinic set rates
- Use a Uniform CDM for all payers
- Update in PM Annually

Annually Update Your EHR & PM Software



Prep your Electronic Health Record (EHR) and Practice Management (PM) Software to accommodate the annual changes required to follow new coding guidelines, compliance requirements and value-based payment program participation.

Key CMS Final Rule Coding and Payment Updates

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Preventive Vaccine Administration

- CMS maintained the additional payment for in-home administration of a COVID-19 vaccine.
- In addition, CMS extended this additional payment to three other preventive service vaccines: **pneumococcal, influenza, and hepatitis B** when provided in the home.
- Beginning January 1, 2024, this standardizes the payment amount for all four vaccines instead of paying more for COVID-19.
- **The additional payment will be limited to one additional payment per home, even if multiple vaccines are administered.**



Vaccine Administration

90460: Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

+90461: Each additional vaccine/toxoid component administered (list separately in addition to code for primary procedure)

Z23: Encounter for immunization other than in the course of a routine exam. This code is required to identify the types of immunizations given.

2023-2024 Flu Season Payment Allowances

Code	Labeler Name	Vaccine Name	Payment Allowance	Effective Dates
90662	Sanofi Pasteur	Fluzone High-Dose Quadrivalent (2023/2024)	\$73.403	08/01/2023 – 07/31/2024
90672	MedImmune	FluMist Quadrivalent (2023/2024)	\$27.788	08/01/2023 – 07/31/2024
90674	Seqirus	Flucelvax Quadrivalent (2023/2024) (Preservative Free)	\$34.172	08/01/2023 – 07/31/2024
90682	Sanofi Pasteur	Flublok Quadrivalent (2023/2024) (Preservative Free)	\$73.403	08/01/2023 – 07/31/2024
90686	GlaxoSmithKline	Fluarix Quadrivalent (2023/2024) (Preservative free)	\$22.350	08/01/2023 – 07/31/2024
		Flulaval Quadrivalent (2023/2024) (Preservative Free)		
	Sanofi Pasteur	Fluzone Quadrivalent (2023/2024) (Preservative Free)		
	Seqirus	Afluria Quadrivalent (2023/2024) (Preservative Free)		

<https://www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing>



2023-2024 Flu Season Payment Allowances

Code	Labeler Name	Vaccine Name	Payment Allowance	Effective Dates
90687	Sanofi Pasteur	Fluzone Quadrivalent 0.25ml (2023/2024)	\$10.439	08/01/2023 - 07/31/2024
	Seqirus	Afluria Quadrivalent 0.25ml (2023/2024)		
90688	Sanofi Pasteur	Fluzone Quadrivalent (2023/2024)	\$20.878	08/01/2023 - 07/31/2024
	Seqirus	Afluria Quadrivalent (2023/2024)		
90694	Seqirus	Fluad Quadrivalent (2023/2024) (Preservative Free)	\$77.359	08/01/2023 - 07/31/2024
90756	Seqirus	Flucelvax Quadrivalent (2023/2024)	\$32.374	08/01/2023 - 07/31/2024

<https://www.cms.gov/medicare/payment/part-b-drugs/vaccine-pricing>



COVID-19 Vaccines & Certain Monoclonal Antibodies

Payment Allowances & Effective Dates for COVID-19 Vaccines & Their Administration: (DOS = Date of Service, TBD = To Be Determined)

CPT Code or HCPCS Code	CPT or HCPCS Short Descriptor	Labeler Name	Vaccine/Procedure Name	National Payment Allowance Effective for Claims with DOS on or after 03/15/2021	National Payment Allowance Effective for Claims with DOS through 03/14/2021	Effective Dates for Medicare Payment
90480	ADMN SARSCOV2 VACC 1 DOSE	N/A	N/A	\$40.000 ^[2]	Code not active during this time	09/11/2023 - TBD
M0201	Covid-19 vaccine home admin	Home vaccine admin	Covid-19 vaccine administration inside a patient's home; reported only once per individual home per date of service when only covid-19 vaccine administration is performed at the patient's home	\$35.50 ^[2]	Code not active during this time	06/08/2021 - TBD
91304	SARSCOV2 VAC 5MCG/0.5ML IM	Novavax	Novavax Covid-19 Vaccine, Adjuvanted (Aged 12	\$148.200 ^[7]	Code not active	07/13/2022 - TBD

Caregiver Training

The Servicing Provider must be a Physician of non-physician practitioner (NPP) to include:

- Nurse Practitioners
- Certified Nurse-Midwives
- Physician Assistants
- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Speech Language Pathologists

CMS finalized proposals to make payments when providers train and involve caregivers to support patients with certain diseases or illnesses in carrying out a treatment plan.



The volume and frequency of **Caregiver Training Services (CTS)** sessions furnished to caregivers by the treating practitioner for the same patient may be based on:

- The treatment plan, as well as
- Changes in patient condition

Caregiver Training

Now a billable service when there is a need to educate caregivers of individual or groups of patients with or without the patient present.

Report CPTs: 97550, 95771 (total F2F time),
97552 (Group Training), 96202 or 96203



Caregiver: an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation and a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition.

What are Social Determinants of Health (SDoH)?

Social determinants of health (SDOH) are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems. Centers for Disease Control and Prevention (CDC) has adopted this SDOH definition from the [World Health Organization](#)



How can Healthcare Providers Demonstrate Risk?

Avoid unspecified
diagnosis codes

Validate illness severity
and risk of mortality

Follow Medical Decision
Making Guidelines

Append Z codes as
secondary diagnosis
codes

CY 2024 Reimbursable SDOH Services

- ❖ SDOH Risk Assessment should last between 5-15 minutes and not be performed more than every 6 months per provider
- ❖ Report HCPCS **G0136** for Medicare beneficiaries. Check commercial payers CPT codes.
- ❖ CMS distinguishes between risk assessment and screening. SDOH risk assessment refers to a review of an individual's SDOH or identified social risk factors that influence the diagnosis and treatment of medical conditions.
- ❖ The SDOH risk assessment is reimbursable when performed in conjunction with an allowable associated visit.
- ❖ The final rule is flexible in terms of which evidence-based risk assessment tool is used and approaches to documentation.

Social Determinants of Health

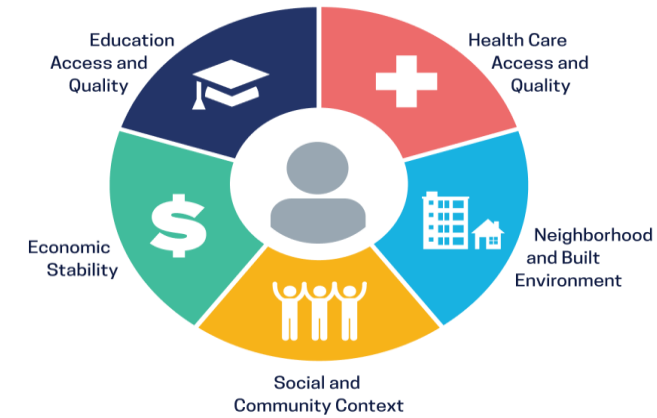


Image Credit: providencechc.org

SDOH Services

- ❖ Community Health Workers, Care Navigators and Peer Support Specialists can perform these services incident-to a Qualified Healthcare Provider (QHP) as auxiliary staff
- ❖ These CPT/HCPCS codes are to be used to pay for these services by non-physician practitioners
- ❖ CMS has not given final guidance on the frequency requirements and limitations for the G0022; which is an add-on code
- ❖ SDOH Services have now been characterized as Care Management services and E/M has been removed from the code descriptor

Social Determinants of Health



Image Credit: providencechc.org

Community Health Integration (CHI) and Principal Illness Navigation (PIN) Billable per Calendar Month

CHI Goal: To address unmet SDOH needs which may impact diagnosis and treatment of a patient.

- **HCPCS G0019 (\$80.28)**– CHI services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit.
- **HCPCS G0022 (\$50.07)**– CHI services, each additional 30 minutes per calendar month.

PIN Goal: To support people with Medicare who are diagnosed with **high-risk** conditions and to connect them with appropriate support resources and clinical care.

- **HCPCS G0023 (\$80.28)** – PIN services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month.
- **HCPCS G0024 (\$50.07)**– PIN services, additional 30 minutes per calendar month
- **HCPCS G0140 (\$80.28)** - PIN – Peer Support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month (*behavioral health*)
- **HCPCS G0146 (\$50.07)**- PIN – Peer Support, additional 30 minutes per calendar month (List separately in addition to G0140) (*behavioral health*)

CY 2024 Telehealth Updates

- Qualified occupational therapists, qualified physical therapists, qualified speech-language pathologists, and qualified audiologists have been added to the list of accepted telehealth practitioners *through December 31, 2024*.
- CMS will continue payment for telehealth services rendered by **Rural Health Clinics (RHCs)** and **Federally Qualified Health Centers (FQHCs)**.
- CMS will continue to delay the in-person requirement to within six months prior to initiating mental health telehealth services.
- Beginning in CY 2024, claims for telehealth services billed with POS 10 will be paid at the non- facility PFS rate. Claims billed with POS 02 will continue to be paid at the facility rate.



CY 2024 Telehealth Updates

- Added health and well-being coaching services to the Medicare Telehealth Services List **temporarily** for CY 2024
- Added SDOH Risk Assessments (G0136) on a **permanent** basis beginning in CY 2024
- Confirmed the originating site of service is to include any site within the U.S. where the beneficiary is located at the point of service *through December 31, 2024*
- Through CY 2024, CMS will continue to permit the distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home.



Telehealth Supervision Guidelines

- Direct supervision will continue to be defined as supervising practitioners who are “immediately available” via real-time audio and visual interactive telecommunications through CY 2024.
 - Notably, CMS is seeking feedback on direct supervision, audio-only services, and the use of telehealth in rural and underserved areas.
- CMS finalized language to permit teaching physicians to use audio/video real-time communications technology when the resident furnishes Medicare telehealth services in all residency training locations through CY 2024.

CY 2024 Medicare Telehealth Services

List <https://www.cms.gov/medicare/coverage/telehealth/list-services>

CMS Incident To Guidelines

- Are **an integral part of the patient's normal treatment** when the physician or other listed practitioner personally performed an initial service and remains actively involved in the course of treatment.
- Are commonly provided without charge or included in the physician's or other listed practitioner's bill.
- **Are an expense to the physician** or other listed practitioner.
- Are commonly provided in the physician's or other listed practitioner's office or clinic.
- Physician or other listed **practitioner provides direct supervision** for the "incident to" services, and only the physician or other listed practitioner who supervises the incident to services may bill them.
- We require general supervision by a physician or other listed practitioner when clinical staff have services and supplies provided incident to
- Only the supervising physician or other listed practitioner may bill services and supplies incident to TCM and CCM services. Additionally, we require general supervision by a physician or other listed practitioner for behavioral health services provided by auxiliary personnel incident to the professional services of a physician or other listed practitioner.

Opioid Treatment Program (OTPs) Updates

Audio-only telecommunications will be payable through the end of CY 2024 for OTPs **when video is not available to the beneficiary**. This allowance is only to the extent permitted by SAMHSA and DEA requirements at the time of service.

Behavioral Health Services Provider Medicare Enrollment Expansion

- FFS payment for **Marriage and Family Therapists (MFTs)** and **Mental Health Counselors (MHCs)**, permitting MFTs and MHCs to provide integrated behavioral health as part of a primary care setting.
- **Addiction counselors** who meet the requirements to be an MHC to enroll in Medicare as MHCs.
- For Medicare purposes, **alcohol and drug counselors** who furnish addiction counseling services for the diagnosis and treatment of mental illnesses, including substance use disorders, can enroll in Medicare and bill as MHCs, to the extent that they meet all of the statutory requirements regarding education, clinical supervised experience, and licensure.

Care Management for Behavioral Health Conditions

CMS finalized their proposal to update the code descriptor for HCPCS code G0323,

G0323 - Care management services for behavioral health conditions, at least 20 minutes of **clinical psychologist, clinical social worker, mental health counselor, or marriage and family therapist** time, per calendar month.

These services include the following required elements:

- Initial assessment or follow-up monitoring,
- Including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems,
- Including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy,
- Coordination with and/or referral to physicians and practitioners who are authorized by Medicare to prescribe medications and furnish E/M services,
- Counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

Health Behavior Assessment and Intervention (HBAI)

Used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment or management of physical health problems.

Indications:

The Health and Behavioral Assessment, initial and Reassessment and Intervention services may be considered reasonable and necessary for the patient who meets all of the following criteria:

- The patient has an underlying physical illness or injury, and
- There are indications that biopsychosocial factors may be significantly affecting the treatment or medical management of an illness or an injury, and
- The patient is alert, oriented and has the capacity to understand and to respond meaningfully during the face-to-face encounter, and
- The patient has a documented need for psychological evaluation or intervention to successfully manage his/her physical illness, and activities of daily living, and
- The assessment is not duplicative of other provider assessments

Health Behavior Assessment and Intervention (HBAI)

CMS finalized the following **Health Behavior Assessment and Intervention (HBAI)** services and any successor codes to be billed by:

- Clinical social workers
- MFT
- MHCs
- Clinical psychologists

Approved CPT codes for HBAI are:

- 96156, 96158-9
- 96164-5, 96167-8

There will be a 19.1% increase to the wRVU's over the course of 4 years

Administrative CMS Program Updates

CY 2024 Medicare Beneficiary Deductibles



Image Credit: Dreamstime

- Part B Enrollees
 - Monthly Premium \$174.70
 - Monthly Premium \$164.90 in 2023
 - Annual deductible \$240
 - Annual deductible \$226 in 2023
 - Part B Coinsurance – 20%
- Part A Enrollees
 - Admission Deductible \$1,632
 - Admission Deductible \$1,600 in 2023
 - Coinsurance Amounts
 - \$408 per day for the 61st through 90th day of a hospitalization
 - \$816 per day for lifetime reserve days
 - \$204 per day for days 21-100 for SNF extended care services

Insulin Deductible & Copay Updates

CMS finalized their proposal to codify the 2023 rule-making which requires that, for insulin furnished through an item of DME after July 1, 2023 the:

- deductible is waived, and
- coinsurance is limited to \$35 for a month's supply of insulin furnished through a covered DME item.

CY 2024 Risk Adjustment Updates

"The cap of the regional risk score growth would apply independent of the cap on an ACO's prospective HCC risk score growth. The regional risk score growth cap would effectively increase the regional component of the update for ACOs in regions with an aggregate regional prospective HCC risk score growth above the cap. CMS believes capping the regional risk score growth will strengthen the incentive for ACOs to operate in regions with high-risk score growth and treat high-risk beneficiaries."

- MGMA

CMS Provider Enrollment Updates

CMS finalized several changes with modifications to what was originally proposed:

- Creating “stay of enrollment” as a new provider enrollment status
- Requiring all providers and suppliers to report additions, deletions or changes in their practice locations within 30 days
- Several changes to denial and revocation authority

Provider Enrollment Chain and Ownership System (PECOS)

<https://pecos.cms.hhs.gov/pecos/login.do#headingLv1>



(*) Red asterisk indicates a required field.

PECOS supports the Medicare Provider and Supplier enrollment process by allowing registered users to securely and electronically submit and manage Medicare enrollment information.

New to PECOS? View our [videos](#) at the bottom of this page.

SYSTEM NOTIFICATIONS

- **Notice: PECOS 2.0 is still under development. CMS is not affiliated with any private company to provide training on PECOS 2.0. ALL current information about the new system is available for free at <https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/provider-enrollment-chain-ownership-system-pecos/introducing-pecos-20>. Any authorized trainings in the future would be offered by CMS or MACs, free of charge.**
- **CMS National Provider Enrollment Conference in San Diego - August 28 & 29**
Wednesday, August 28 & Thursday, August 29 from 8 am to 5 pm PT
San Diego, California
[Register](#) for the CMS National Provider Enrollment Conference at the San Diego Convention Center. Take advantage of this opportunity to meet with CMS and Medicare Administrative Contractor provider enrollment experts.

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Please use your I&A (Identity & Access Management System) user ID and password to log in.

* User ID

* Password

LOG IN >>

BECOME A REGISTERED USER

You may register for a user account if you are: an Individual Practitioner, Authorized or Delegated Official for a Provider or Supplier Organization, or an individual who works on behalf of Providers or Suppliers.

[Register for a user account](#)

[Questions? Learn more about registering for an account](#)

Note: If you are a Medical Provider or Supplier, you must [register for an NPI](#) before enrolling with Medicare.

CY 2024 MIPS & APM

MIPS Updates

Quality	Improvement Activities	Promoting Interoperability	Cost	Data Completeness
• 30%	• 15%	• 25%	• 30%	• 75%

APM Updates

- Expiration of the 3.5% APM Incentive Payment after the 2023 performance year/2025 payment year
- Transition to a Qualifying APM Conversion Factor in the 2024 performance year/2026 payment year

New MIPS Value Pathways (MVP):

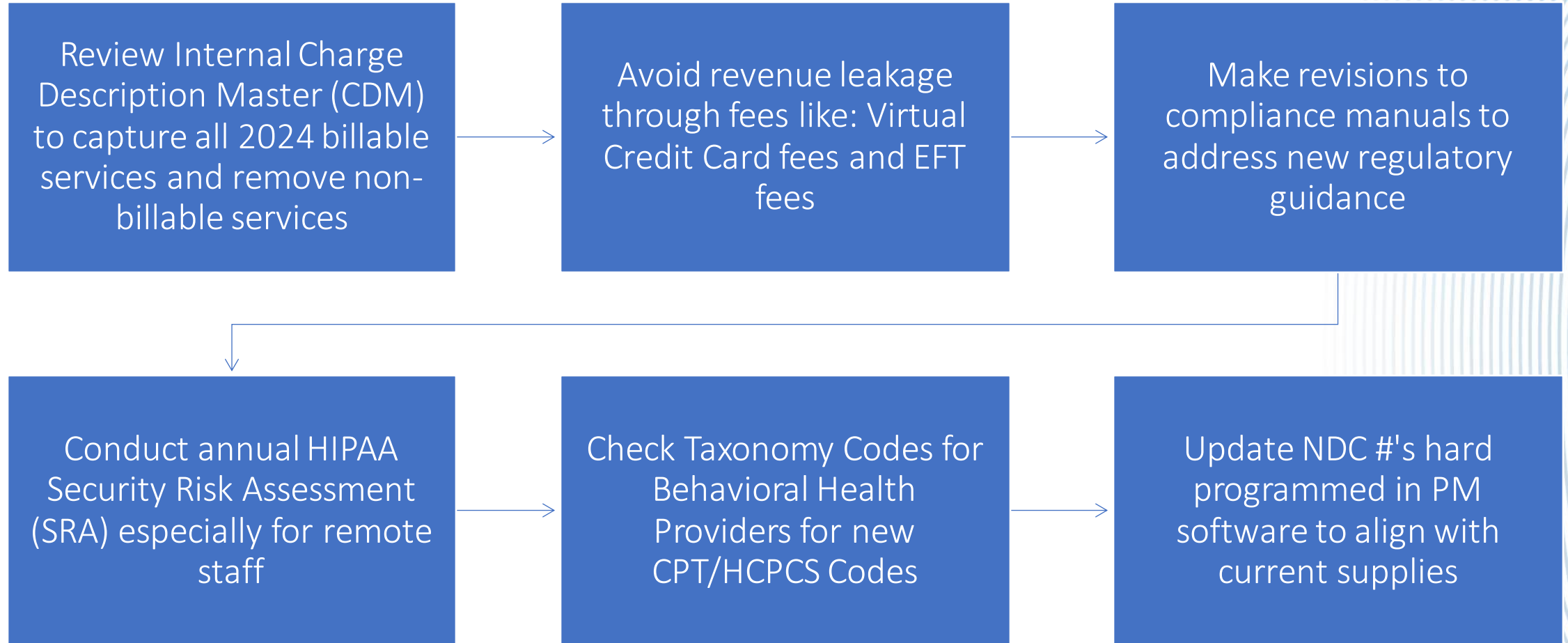
1. Focusing on Women's Health
2. Quality Care for the Treatment of Ear, Nose, and Throat Disorders
3. Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
4. Quality Care in Mental Health and Substance Use Disorders
5. Rehabilitative Support for Musculoskeletal Care

Medicare Shared Savings Program (MSSP) Updates

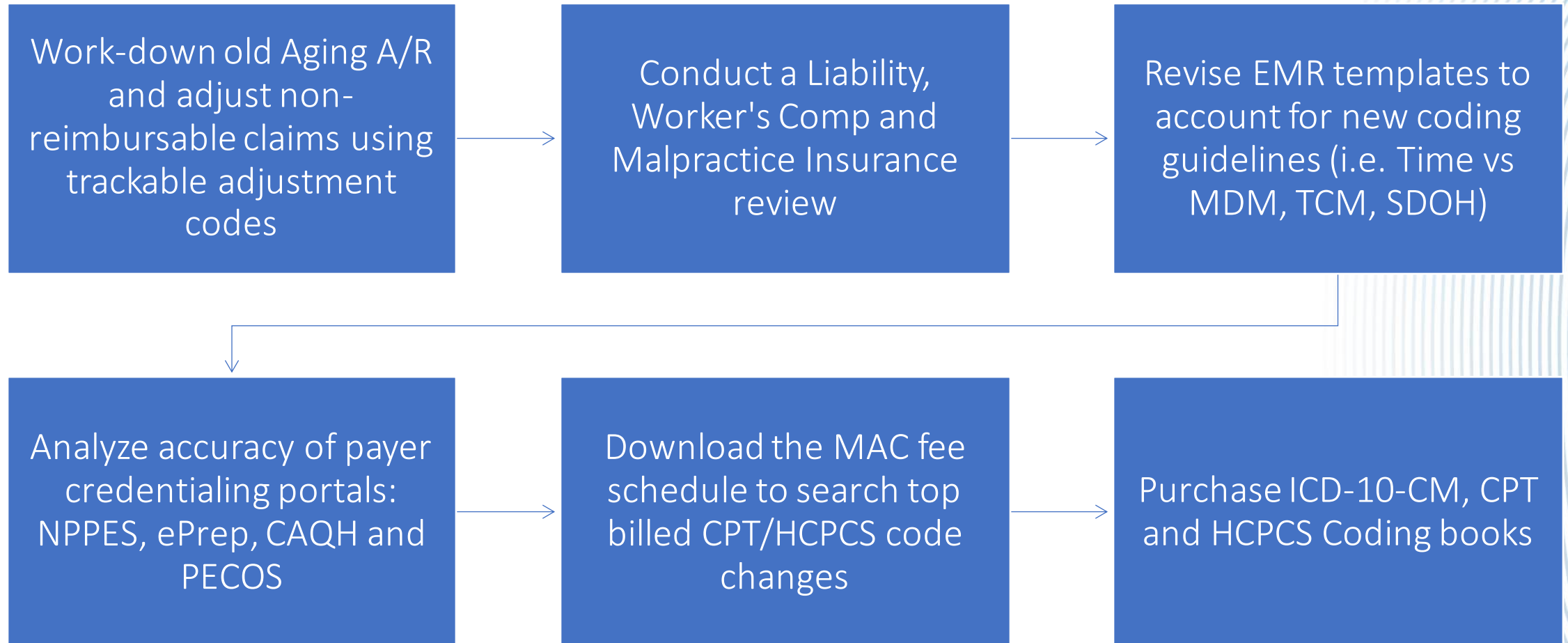
- ❑ New Clinical Quality Measures (CQMs) for **Accountable Care Organizations (ACOs)** as a new collection type for ACOs within the **Alternative Payment Model (APM) Performance Pathway (APP)**.
- ❑ Reporting CQMs would make ACOs eligible for the health equity adjustment to their quality performance category score.
- ❑ The final year for ACOs to report quality data using the CMS Web Interface is 2024

Preparing for Success in 2024

Preparing for a Successful Year



Preparing for a Successful Year



CMS Resources

- PFS Final Rule Fact Sheet:

<https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule-medicare-shared-savings-program>

- MSSP Final Rule Fact Sheet:

<https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule-medicare-shared-savings-program>

- QPP Final Rule Facts and Resources:

<https://qpp.cms.gov/resources/resource-library>



Image Credit: wallpapercave.com

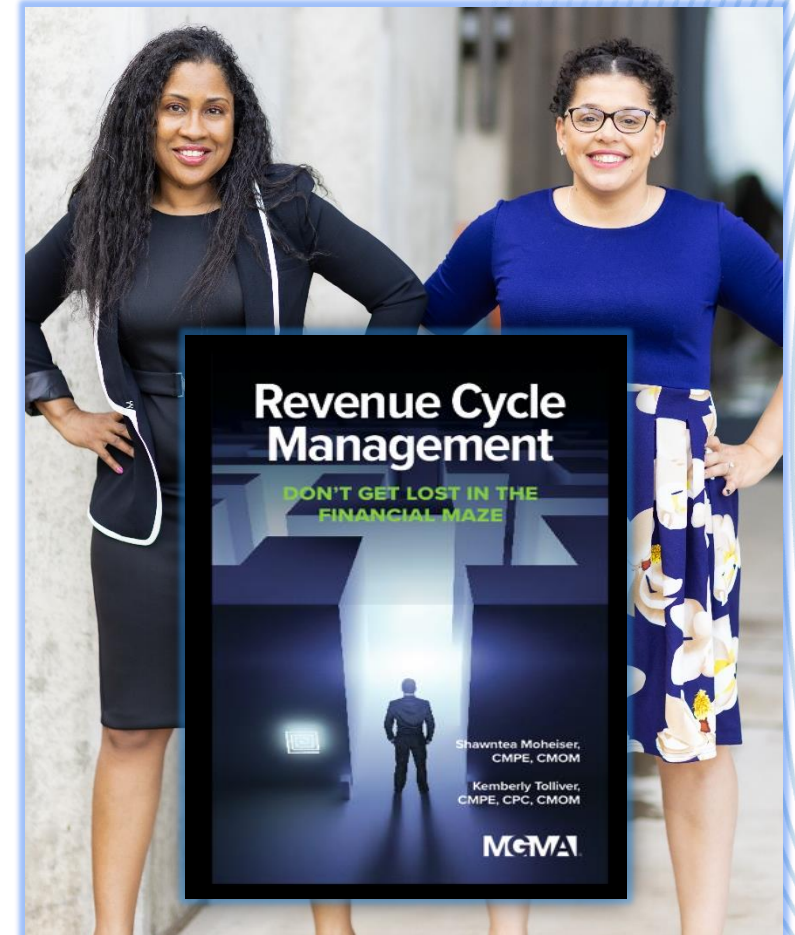
Bring on the Questions and Comments

Resource Alert

Co-Authors of MGMA's Revenue Cycle Management Don't Get Lost in the Financial Maze + Advanced Strategy for Medical Practice Leaders



Co-Hosts of the
"Slice of
Healthcare"
Podcast:





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REVENUE CYCLE
SPECIALISTS

Thank You & Let's Stay Connected



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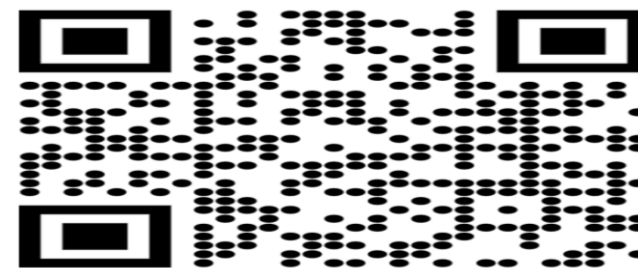
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