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Thank you for joining today's webinar. We will begin promptly at 2:00 pm Central.

2024 Physician Fee Schedule Final Rule

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2024 Physician Fee Schedule Final Rule

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Housekeeping

- Slides are available at https://www.ruralhealthinfo.org/webinars/physician-fee-schedule
- Technical difficulties please visit the Zoom Help Center at support.zoom.us

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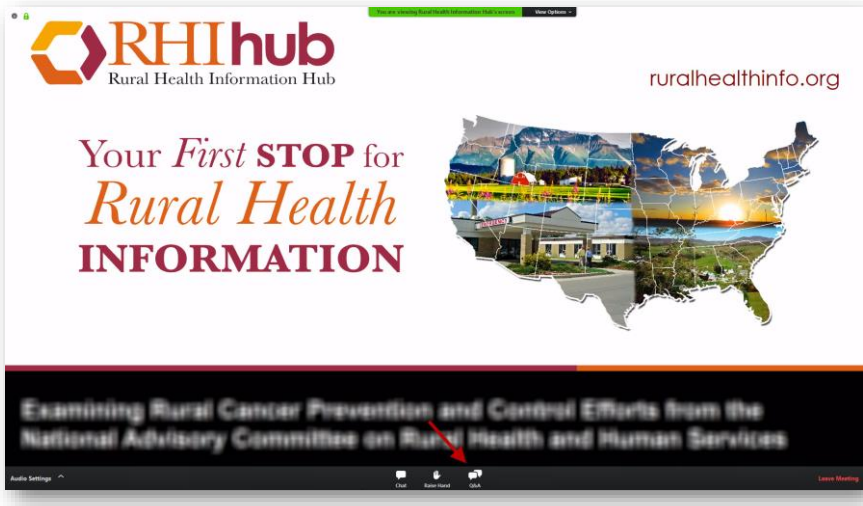
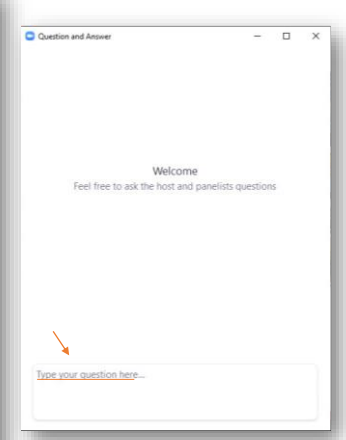
If you have questions…





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Featured Speakers

Sarah Heppner, Associate Director, Federal Office of Rural Health Policy

Lindsey Baldwin, Division of Ambulatory Services, Hospital and Ambulatory Policy Group, CMS Center for Medicare

Gift Tee, Division of Practitioner Services, Hospital and Ambulatory Policy Group, CMS Center for Medicare

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Michele Franklin, Division of Ambulatory Services, Hospital and Ambulatory Policy Group, CMS Center for Medicare

Colleen Barbero, Medicare Diabetes Prevention Program, CMS Center for Medicare and Medicaid Innovation

Tina Cooley, Medicare Diabetes Prevention Program, CMS Center for Medicare and Medicaid Innovation

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

HRSA Update

CMS Presentation
CY 2024 Physician Fee Schedule Overview

February 2024

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CY 2024 PFS Final Rule Highlights - 1

On November 2, 2023, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that includes policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, effective on or after January 1, 2024.

The Physician Fee Schedule (PFS) final rule announces policy changes for Medicare payments under the PFS for CY 2024. In addition to the final CY 2024 PFS payment rates, the final rule includes policies aiming to advance health equity under Medicare Part B; helping patients navigate cancer treatment and treatment for other high-risk conditions; providing for Medicare Parts A and B payment for certain dental services and closely examining the relationship between dental services and certain kinds of cancer treatment; expanding access to behavioral health services through the implementation of key provisions authorized by Congress; adopting the office/outpatient evaluation and management visit complexity add-on code to improve payment for primary and longitudinal care; continuing Public Health Emergency (PHE) flexibilities under the Medicare Diabetes Prevention Program (MDPP) Expanded Model; and updating the Medicare Shared Savings Program and the Quality Payment Program.

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CY 2024 PFS Final Rule Highlights -2

Some of the topics covered in the final rule include:

- CY 2024 PFS Ratesetting and Conversion Factor
- Evaluation and Management Services – Complexity add-on
- Behavioral Health Services
- Dental and Oral Health Services
- Telehealth Services
- Caregiver Training Services
- Social Determinations of Health (SDOH) Risk Assessment
- Community Health Integration (CHI) and Principal Illness Navigation (PIN) Services
- RHCs and FQHCs

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CY 2024 PFS Ratesetting and Conversion Factor – 2

- The CY 2024 PFS final rule presents a series of standard technical changes involving practice expense, including the implementation of the third year of the clinical labor pricing update, and standard rate-setting refinements.
- The Consolidated Appropriations Act, 2023 provided a temporary 2.50 percent increase in PFS payments for CY 2023, and a 1.25 percent increase for CY 2024. This is a statutory provision that CMS does not have regulatory authority to alter.
- With the budget neutrality adjustment to account for changes in RVUs (required by law), and expiration of the 2.50 percent payment increase provided for CY 2023, and the 1.25 percent increase for CY 2024 by the Consolidated Appropriations Act, 2023 , the finalized CY 2024 PFS conversion factor is $32.74, a decrease of $1.15 (3.4 percent) from the CY 2023 PFS conversion factor of $33.89.

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Evaluation and Management (E/M) Services – O/O E/M Visit Inherent Complexity Add-On Code - 1

- **O/O E/M Visit Inherent Complexity Add-On Code**
  - CMS finalized implementation of a separate add-on payment, beginning January 1, 2024, for healthcare common procedure coding system (HCPCS) code G2211.
  - This add-on code will better recognize the resource costs associated with evaluation and management visits for primary care and longitudinal care. Generally, it will be applicable for outpatient and office visits as an additional payment, recognizing the inherent costs involved when clinicians are the continuing focal point for all needed services, or are part of ongoing care related to a patient's single, serious condition or a complex condition.
  - For example, a primary care clinician, as the continuing focal point for all needed health care services for a patient, often bears the cognitive load, responsibility, and an accountability for building the most effective, trusting relationship possible amidst evaluating and managing other health care problems during a visit. Building an effective longitudinal relationship, in and of itself, is a key aspect of providing reasonable and necessary medical care and will make the patient more likely to comply with treatment recommendations after the visit and during future visits. It's the work building this important relationship between the practitioner and patient for primary and longitudinal care that has been previously unrecognized and unaccounted for during evaluation and management visits. In the rule, CMS provided greater detail on how clinicians can utilize the code, as requested by commenters, and may produce educational materials as is necessary.

Evaluation and Management (E/M) Services – O/O E/M Visit Inherent Complexity Add-On Code - 2

- **Applicability for RHCs and FQHCs**
  - RHCs and FQHCs are not paid according to the complexity of the patient. CMS pays an encounter rate for each billable visit that accounts for all services furnished to a beneficiary for the day, with some exceptions. Therefore, services described by HCPCS code G2211 are accounted for in the payment of the billable visit for that day. RHCs are paid under the RHC All-Inclusive Rate methodology and FQHCs are paid under the FQHC PPS. HCPCS code G2211 is not paid separately.

Behavioral Health Services – 1

- **Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)**
  - For CY 2024, we finalized our proposal to implement Section 4121 of the CAA, 2023, which provides for Medicare Part B coverage and payment under the Medicare Physician Fee Schedule for the services of marriage and family therapists (MFTs) and mental health counselors (MHCs) when billed by these professionals.
  - Additionally, we finalized our proposal to allow addiction counselors or drug and alcohol counselors who meet the applicable requirements to be an MHC to enroll in Medicare as MHCs.
  - MFTs and MHCs will be able to begin submitting Medicare enrollment applications after the CY 2024 Physician Fee Schedule final rule is issued, and they will be able to bill Medicare for services starting January 1, 2024, consistent with statute.
  - We also made corresponding changes to Behavioral Health Integration codes to allow MFTs and MHCs to bill for these services.

Behavioral Health Services – 2

- **Psychotherapy for Crisis Services**
  - We are implementing Section 4123 of the CAA, 2023, which requires the Secretary to establish new HCPCS codes under the PFS for psychotherapy for crisis services that are furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting, including the home or a mobile unit) furnished on or after January 1, 2024.
  - Section 4123 of the CAA, 2023 specifies that the payment amount for psychotherapy for crisis services shall be equal to 150% of the fee schedule amount for non-facility sites of service for each year for the services identified (as of January 1, 2022) by HCPCS codes 90839 (*Psychotherapy for crisis; first 60 minutes*) and 90840 (*Psychotherapy for crisis; each additional 30 minutes — List separately in addition to code for primary service*), and any succeeding codes.

Behavioral Health Services – 3

- **Other Behavioral Health Services**
  - We finalized our proposal to allow the Health Behavior Assessment and Intervention (HBAI) services described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168, and any successor codes, to be billed by clinical social workers, MFTs, and MHCs, in addition to clinical psychologists.
  - We also finalized an increase in the valuation for timed behavioral health services under the PFS. Specifically, we finalized our proposal to apply an adjustment to the work RVUs for psychotherapy codes payable under the PFS, which we are implementing over a four-year transition.
    - In response to public comments, we also finalized the application of this adjustment to psychotherapy codes that are billed with an E/M visit and to the HBAI codes. We believe that these finalized changes will begin to address distortions that have occurred in valuing time-based behavioral health services over many years.

Behavioral Health Services – RHCs and FQHCs

- **Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) in RHCs and FQHCs. For CY 2024,**
  - MFTs and MHCs are recognized as RHC and FQHC practitioners and the services they furnish are billable visits.
  - The health and safety standards for RHCs and FQHCs were revised with provisions that advance access to behavioral health in rural communities.
- **Other Behavioral Health Services**
  - The required level of supervision for behavioral health services furnished "incident to" a physician or NPP's services in RHCs and FQHCs is general supervision, rather than direct supervision.

Dental and Oral Health Services

For CY 2024, we finalized:

- A codification of the previously finalized payment policy for dental services for head and neck cancer treatments, whether primary or metastatic.
- The codification to permit Medicare Part A and Part B payment for dental or oral examination performed as part of a comprehensive workup prior to medically necessary diagnostic and treatment services, to eliminate an oral or dental infection prior to, or contemporaneously with, those treatment services, and to address dental or oral complications after radiation, chemotherapy, and/or surgery when used in the treatment of head and neck cancer.
- Our proposal to permit payment for certain dental services inextricably linked to other covered services used to treat cancer prior to, or during:
  a) Chemotherapy services
  b) Chimeric Antigen Receptor T- (CAR-T) Cell therapy
  c) The use of high-dose bone modifying agents (antiresorptive therapy)

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Dental and Oral Health Services – 2

- Additionally, in the CY 2024 PFS proposed rule, we also sought comment on additional circumstances where evidence supports dental services being integral to the clinical success of covered medical services, which we may consider for future rulemaking.
- In February 2024, CMS will accept and consider public submissions for potentially analogous clinical scenarios under which Medicare payment could be made for dental services. These submissions will help inform future rulemaking. As part of this process, we encourage members of the public to review the ARHQ's July 2023 report, "Efficacy of Dental Services for Reducing Adverse Events in Those Receiving Chemotherapy," as an example of the clinical analyses CMS solicits to inform future rulemaking on dental services and care inextricably linked to medical need in the Medicare population.

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Telehealth Services Under the PFS

For CY 2024, we finalized:

- Our proposal to add health and well-being coaching services to the Medicare Telehealth Services List on a temporary basis for CY 2024. We also finalized the addition of HCPCS code G0136 (Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5-15 minutes) to the Medicare Telehealth Services List.
- A refined process to analyze requests received for changes to the services included on the Medicare Telehealth Services List, including a determination of whether requested services should be added on a permanent or provisional basis.
- Claims billed with POS 10 (Telehealth Provided in Patient's Home) would be paid at the non-facility PFS rate. We believe this policy will protect access to mental health and other telehealth services by aligning with telehealth-related flexibilities that were extended via the CAA, 2023.
- Removal of frequency limitations for Subsequent Inpatient Visits, Subsequent Nursing Facility Visits, and Critical Care Consultation for 2024, and we sought and received comment from interested parties on how practitioners have been ensuring that Medicare beneficiaries receive subsequent inpatient and nursing facility visits, as well as critical care consultation services since the expiration of the PHE.

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Telehealth Services Under the PFS – 2

- For CY 2024, we also finalized the continuation of our revised direct supervision policy to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2024. In the proposed rule, we solicited comment on whether we should consider extending the definition of direct supervision to permit virtual presence beyond December 31, 2024. We received input from interested parties on potential patient safety or quality concerns when direct supervision occurs virtually, which we will consider for future rulemaking.
- Additionally, we also extended PHE flexibilities to allow practitioners furnishing telehealth services from their homes to report their office addresses on their enrollment forms. This extension aligns with telehealth-related flexibilities that were extended via the CAA, 2023, and addresses practitioner privacy and safety concerns about including their home addresses as practice locations on their enrollment forms.

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Telehealth Services Under the PFS – 3

Telehealth Services Furnished in Teaching Settings

- CMS finalized a policy to allow teaching physicians in all training settings to be present using audio/video real-time communications technology when a resident is providing Medicare telehealth services consistent with other applicable telehealth policies. This virtual presence would meet the requirement that the teaching physician can bill under the PFS for the service involving the resident if they are present for the key portion of the service. The virtual presence policy applies in all teaching settings through December 31, 2024.

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Telehealth Services for RHCs and FQHCs

For CY 2024,

- Extending payment for telehealth services through use of billing HCPCS code G2025 through December 31, 2024.
- Delaying the in-person requirements under Medicare for mental health visits furnished via telecommunications technology.
- For direct supervision, we continue permitting the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2024.

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Advancing Health Equity and Caregiver Support

Building on the agency's commitment to health equity, and the Biden-Harris Administration's Executive Order to support caregivers, CMS is finalizing separate coding and payment for several new services to help underserved populations, including addressing unmet health related social needs that can potentially interfere with the diagnosis and treatment of medical problems, paying for new navigation services to help people with cancer and other serious illnesses navigate their treatment, supporting family caregivers, paying for services involving community health workers to address health-related social needs that impact care, and enhancing access to dental care for people with certain cancers. Taken holistically, these are some of the largest policy changes in Medicare payment that aim to put patients at the center of the care they receive.

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Caregiver Training Services

- For CY 2024, CMS finalized its proposal to make payment when practitioners train caregivers to support patients with certain diseases or illnesses (e.g., dementia) in carrying out a treatment plan.
- Medicare will pay for these services when furnished by a physician or a non-physician practitioner (nurse practitioners, clinical nurse specialists, certified nurse-midwives, physician assistants, and clinical psychologists) or therapist (physical therapist, occupational therapist, or speech language pathologist) as part of the patient's individualized treatment plan or therapy plan of care.
- This action, consistent with the recent Biden-Harris Administration Executive Order on Increasing Access to High Quality Care and Supporting Caregivers, will help support care for persons with Medicare by better training caregivers.

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Social Determinations of Health (SDOH) Risk Assessment

- We finalized coding and payment for SDOH risk assessments to recognize when practitioners spend time and resources assessing SDOH that may be impacting their ability to treat the patient. We are finalizing the addition of the SDOH risk assessment to the annual wellness visit as an optional, additional element with an additional payment and no patient coinsurance nor deductible (when provided with the annual wellness visit).
- We also finalized codes and payment for SDOH risk assessments furnished with an evaluation and management or behavioral health visit.

Community Health Integration (CHI) and Principal Illness Navigation (PIN) Services

- For CY 2024, we finalized specific coding and payment for monthly Community Health Integration (CHI) and Principal Illness Navigation (PIN) services to account for when clinicians involve auxiliary personnel such as community health workers and care navigators to support patients who have unmet needs that affect the diagnosis and treatment of their medical problems and when certain patients with high-risk conditions need assistance connecting with appropriate clinical and other resources.
- These services support equity, inclusion, and access to care for the Medicare population, aligned with the HHS Social Determinants of Health Action Plan and the Biden-Harris Cancer Moonshot Initiative, and may improve the outcomes for the patient.

Community Health Integration (CHI) and Principal Illness Navigation (PIN) Services – 2

- CHI and PIN services involve a person-centered assessment to better understand the patient's life story, care coordination, contextualizing health education, building patient self-advocacy skills, health system navigation, facilitating behavioral change, providing social and emotional support, and facilitating access to community-based social services to address unmet social determinations of health (SDOH) needs.
- We also finalized a new set of additional PIN codes that practitioners may bill when specifically supervising auxiliary personnel such as peer support specialists to support patients with behavioral health conditions that meet the qualifications of a serious, high-risk illness as outlined in PIN.
  - These services will generally match PIN requirements, with some changes in the types of services provided to align with existing standards of peer support work. These services will be provided by auxiliary personnel under general supervision incident to a billing practitioner.

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Advancing Health Equity in RHCs and FQHCs

For CY 2024,

- **Social Determinations of Health (SDOH) Risk Assessment**
  - When SDOH risk assessment (G0136) is furnished as an additional element of the AWV, one visit will be paid, that is, paid under the RHC AIR methodology for RHCs or under the FQHC PPS with the AWV adjustment for FQHCs. No beneficiary cost sharing.
  - When the SDOH risk assessment is furnished with a billable visit (other than an AWV) on the same day in an RHC, one visit will be paid under the AIR methodology. Beneficiary coinsurance and deductible are applicable.
  - For FQHCs, the SDOH risk assessment is not considered a qualifying visit. When the assessment is furnished in conjunction with a qualifying visit (other than an AWV) on the same day in a FQHC, one visit will be paid under the FQHC PPS. Beneficiary coinsurance are applicable.
- **Community Health Integration (CHI) Services (G0019), Principal Illness Navigation (PIN) Services (G0023), and Principal Illness Navigation (PIN) Services – Peer Support (G0140)**
  - When the services described by these HCPCS codes are furnished, RHCs and FQHCs may bill the general care management HCPCS code G0511, either alone or with other payable services.

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General Care Management Services in RHCs and FQHCs

For CY 2024,

- When remote physiologic monitoring (RPM) services and/or remote therapeutic monitoring (RTM) services are furnished, RHCs and FQHCs may bill the general care management HCPCS code G0511, either alone or with other payable services
- CMS revised the methodology to calculate the payment rate for the general care management HCPCS code G0511 to take into account how frequently the various services are utilized.
- Clarified that direct supervision is not needed for beneficiary consent for Chronic Care Management and virtual communication services.

General Care Management Services in RHCs and FQHCs

HCPCS Code G0511 (General Care Management) is comprised of the services listed in the Table below.

When RHCs and FQHCs furnish services described by the codes below, they may bill G0511 multiple times in a calendar month, as long as all of the requirements for each service are met.

General Care Management Services	HCPCS/CPT Codes
CCM	99487, 99490, 99491
PCM	99424, 99426
CPM	G3002
General BHI	99484
RPM	99453, 99454, 99457, 99091
RTM	98975, 98976, 98977, 98980
CHI	G0019
PIN	G0023
PIN – Peer Support	G0140

Intensive Outpatient Program (IOP) Services - 1

Effective January 1, 2024, IOP services may be furnished in hospital outpatient departments, Community Mental Health Centers (CMHCs), FQHCs, and RHCs. IOP services may also be furnished in Opioid Treatment Programs (OTPs) for the treatment of opioid use disorder (OUD).

Scope of Benefits

- An IOP is a distinct and organized outpatient program of psychiatric services provided for individuals who have an acute mental illness or substance use disorder, consisting of a specified group of behavioral health services paid on a per diem basis.

Physician Certification and Plan of Treatment Requirements

- A physician must determine that each patient needs a minimum of nine hours of IOP services per week. This determination must occur no less frequently than every other month.

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Intensive Outpatient Program (IOP) Services - 2

IOP Payment Rates in Hospital Outpatient Departments (HODs) and CMHCs

- HODs and CMHCs are paid IOP payment rates for three services per day and four or more services per day.
- IOP payment rates are based on cost per day using Hospital Outpatient prospective payment system (OPPS) data.

IOP Payment Rates and Policy in RHCs and FQHCs

- RHCs and FQHCs are paid an IOP payment rate for three services per day.
- The IOP payment rate is based on the HOD rate, per statute.
- For FQHCs, payment is the lesser of a FQHC's actual charges or the IOP payment rate.
- For grandfathered Tribal FQHCs, payment is based on the lesser of a FQHC's actual charges or the Medicare outpatient per visit rate as established by the Indian Health Service.
- Costs associated with IOP services are not used to determine payment amounts under the RHC all-inclusive rate (AIR) methodology or FQHC PPS.

IOP Payment in Opioid Treatment Programs (OTP)

- OTPs are paid a weekly payment adjustment via an add-on code for IOP services furnished by OTPs for the treatment of OUD.

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Thanks!

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Medicare Diabetes Prevention Program (MDPP): Updates to CY24 PFS

February 27, 2024

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The Problem: The Prevalence and Cost of Diabetes

Diabetes affects many individuals, negatively impacts health outcomes, and carries high costs. Effective behavior change can reduce the risk of type 2 diabetes.

While Many are At-Risk for Diabetes, Few are Aware

1 in 2 Nearly half of adults aged 65 and older have prediabetes[1]

however…

Only one in four adults aged 65 and older with prediabetes are aware of their condition[1]

Diabetes Prevalence is High and Growing

Nearly one in three adults aged 65 and older have diabetes[2]

and…

Prevalence of diabetes is expected to double by 2050 among adults[3]

The Disease Burdens the Nation with High Costs

2.6x Diabetes causes individuals to spend 2.6 times more on health care per year[4]

$205B Medical care for diabetes for persons aged 65 and older cost the nation about $205 billion in 2022. Most of this expenditure was paid by Medicare.[4]

Sources: 1) https://www.cdc.gov/diabetes/data/statistics-report/index.html ; 2) https://www.cdc.gov/diabetes/data/statistics-report/index.html
3) https://www.cdc.gov/media/pressrel/2010/r101022.html; 4) https://diabetes.org/newsroom/press-releases/new-american-diabetes-association-report-finds-annual-costs-diabetes-be

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The Solution: The Medicare Diabetes Prevention Program (MDPP)

A group-based intervention targeting at-risk Medicare beneficiaries, using a CDC-approved National Diabetes Prevention Program curriculum.

Up to 1 year of sessions delivered to groups of eligible beneficiaries.

As a **Medicare preventive service**, there are no out-of-pocket costs.

DIET | PHYSICAL ACTIVITY | WEIGHT LOSS

Coaches furnish MDPP services on behalf of MDPP suppliers

MDPP suppliers' primary goal is to help Medicare beneficiaries achieve at least 5% weight loss

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The Evidence Base: CDC's National Diabetes Prevention Program (DPP)

MDPP builds on the success of the CDC's National DPP. The National DPP is a structured lifestyle intervention that was tested in the Medicare population through an Innovation Center-funded DPP Model Test (Y-USA test).

Decades of Evidence

- Backed by over 20 years of evidence
- Research shows DPP can decrease the risk of type 2 diabetes in individuals with prediabetes by 58% [1]

CDC's National DPP

- Implemented nationally
- CDC established the Diabetes Prevention Recognition Program (DPRP) to set quality assurance standards for the program

DPP Model Test (Y-USA test)

- Assessed DPP effectiveness among the Medicare population
- Showed that group-based community sessions can lead to beneficiary weight loss and Medicare savings

CDC Recognition is the First Step to MDPP Success

DPRP Recognition

- **Organizations must achieve full or preliminary DPRP recognition** before enrolling in Medicare as MDPP suppliers
- DPRP recognition helps assure that organizations have the capacity to become MDPP suppliers

DPRP Curriculum

- **MDPP suppliers utilize a CDC-approved curriculum to deliver MDPP services**
- CDC-approved curricula include evidence-based topics like healthy eating and weight loss

Source: 1) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3135022

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Program Duration and Covered Services

MDPP core services includes six months of weekly core sessions followed by six months of monthly core maintenance sessions.

MDPP Core Sessions	MDPP Core Maintenance Sessions
Months 1-6 (Weekly Sessions)	**Months 7-12 (Monthly Sessions)**
• Up to 16 sessions offered at least a week apart during the first 6 months • In-person and distance learning sessions are available and must meet specific requirements	• Up to 6 monthly sessions during the second 6 months • In-person and distance learning sessions are available and must meet specific requirements

✓ Follows a CDC-approved curriculum ✓ No beneficiary copay ✓ No referral required

Sample Activities: *Fitness Log* *Food Log* *Weight Log*

Source: https://www.cdc.gov/diabetes/prevention/resources/curriculum.html

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MDPP Beneficiary Eligibility Requirements

MDPP is available to Medicare beneficiaries with an indication of prediabetes.

Medicare Eligibility

Beneficiaries must have coverage through Original Medicare (Part B) or Medicare Advantage (Part C)

Blood Tests and Body Mass Index (BMI)

Beneficiaries must present one of three blood tests indicating prediabetes **and** BMI of at least 25 (or 23 if self-identified as Asian).

Other Medical History

Beneficiaries must not have a previous diagnosis of diabetes or End Stage Renal Disease, and no previous receipt of MDPP services

See the *MDPP Beneficiary Disclosure Worksheet* for eligible values for the blood tests:
https://www.cms.gov/files/document/mdpp-bene-disclosure-ws.pdf

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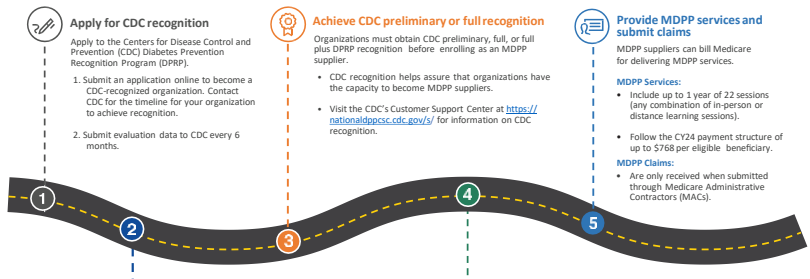
Roadmap to Enrolling as an MDPP Supplier

Before applying to become an MDPP supplier, organizations must gain full or preliminary recognition from CDC.



1 Apply for CDC recognition

Apply to the Centers for Disease Control and Prevention (CDC) Diabetes Prevention Recognition Program (DPRP).

1. Submit an application online to become a CDC-recognized organization. Contact CDC for the timeline for your organization to achieve recognition.
2. Submit evaluation data to CDC every 6 months.

2 Prepare to enroll as an MDPP supplier

Learn about MDPP enrollment requirements as you work towards CDC recognition.

- Visit the MDPP website and review enrollment materials such as the **Enrollment Fact Sheet[1] and the Enrollment Checklist[2].**
- Organizations should obtain a separate NPI to be used for MDPP enrollment in order to reduce claim rejections and denials that may occur if multiple enrollments are associated with a single NPI.

3 Achieve CDC preliminary or full recognition

Organizations must obtain CDC preliminary, full, or full plus DPRP recognition before enrolling as an MDPP supplier.

- CDC recognition helps assure that organizations have the capacity to become MDPP suppliers.
- Visit the CDC's Customer Support Center at https://nationaldppcsc.cdc.gov/s/ for information on CDC recognition.

4 Apply to become an MDPP supplier

Choose one of the options to enroll as an MDPP supplier after gaining CDC recognition:

- Enroll online using the https://pecos.cms.hhs.gov/pecos/login.do.**
- Submit a paper CMS-20134 form.

**Recommended

[1] https://innovation.cms.gov/Files/x/mdpp-enrollmentfs.pdf; [2] https://innovation.cms.gov/Files/x/mdpp-enrollmentcl.pdf

5 Provide MDPP services and submit claims

MDPP suppliers can bill Medicare for delivering MDPP services.

MDPP Services:

- Include up to 1 year of 22 sessions (any combination of in-person or distance learning sessions).
- Follow the CY24 payment structure of up to $768 per eligible beneficiary.

MDPP Claims:

- Are only received when submitted through Medicare Administrative Contractors (MACs).

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CY24 Physician Fee Schedule (PFS) Changes: Access and Equity

- **Extending the Public Health Emergency (PHE) flexibilities until Dec 31, 2027**
  - Allows flexibility in how MDPP set of services are delivered (in-person and distance learning)
  - Expected to increase access to MDPP among at-risk populations who reside in communities underserved by healthcare providers
- **Simplified payment structure expected to result in more regular payments to MDPP suppliers**
  - Reduced # of HCPCS G-Codes from 15 to 6
  - Allows FFS payments for session attendance
  - No Virtual Modifier (replaced with distance learning G-code)
  - Retains performance payments for weight loss

Read the CY24 PFS (Final Rule) here: https://public-inspection.federalregister.gov/2023-24184.pdf.
Read the CDC Diabetes Prevention Recognition Program (DPRP) Standards here: https://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf.

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MDPP Modalities

<u>Virtual delivery limited to the CDC DPRP definition of "distance learning"</u>

- *Distance learning:* MDPP session that is delivered live (synchronous) by a trained Coach in one location and participants call-in or video-conference from another location.
- *Combination delivery:* MDPP sessions that are delivered by trained Coaches through distance learning and in-person sessions for each individual participant.
- *Online delivery:* Sessions that are experienced through the Internet via phone, tablet, laptop, in an asynchronous classroom where participants are experiencing the content on their own time without a live Coach teaching the content. **(Not covered by Medicare FFS)**

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MDPP Billing and Payment: CY 2024 MDPP Payment Structure

HCPCS G-Code	Payment Description*	CY 2024
G9886*	Behavioral counseling for diabetes prevention, in-person, group, 60 minutes	$25
G9887*	Behavioral counseling for diabetes prevention, distance learning, 60 minutes	$25
G9880	5 percent weight loss (WL)Achieved from baseline weight	$145
G9881	9 percent WL Achieved from baseline weight	$25
G9888**	Maintenance 5 percent WL from baseline in months 7-12	$8
G9890	Bridge Payment	$25
	Subtotal Maximum Attendance-Based Payment	**$550**
	Total Maximum Payment	**$768**

*Medicare pays up to 22 sessions billed with codes G9886 and G9887, combined, in a 12-month period:
Months 1-6: 1 in-person or distance learning session every week (max 16 sessions)
Months 7-12: 1 in-person or distance learning session every month (max 6 sessions)
** Suppliers must submit claim for 5 percent weight loss (G9880) prior to submitting claims for the maintenance 5 percent weight loss from baseline in months 7-12 (G9888).

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MDPP General Resources

Access all the latest materials, webinars, and information about MDPP

- MDPP website: https://www.cms.gov/priorities/innovation/innovation-models/medicare-diabetes-prevention-program
- FAQs: https://www.cms.gov/priorities/innovation/innovation-models/medicare-diabetes-prevention-program/faq

Get Support for MDPP Suppliers:

- Submit an inquiry through the MDPP Supplier Support Center: https://cmsorg.force.com/mdpp

Contact the MDPP Model Team with questions or join the MDPP Listserv

- Email us at: mdpp@cms.hhs.gov
- Join the MDPP Listserv: https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_12284

Read the CY2024 PFS Final Rule

- https://www.federalregister.gov/public-inspection/2023-24184/medicare-and-medicaid-programs-calendar-year-2024-payment-policies-under-the-physician-fee-schedule

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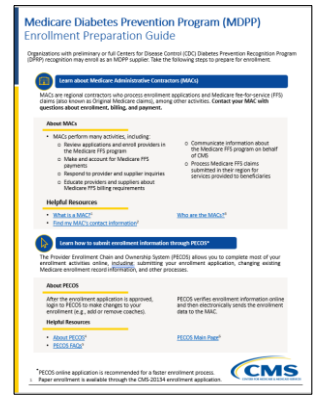
MDPP Enrollment Resources

- MDPP Journey Map: https://www.cms.gov/files/document/mdpp-roadmap-2024.pdf
- MDPP Enrollment Preparation Guide: https://www.cms.gov/files/document/mdpp-enrollment-prep-guide.pdf
- MDPP Enrollment Tutorial: https://www.cms.gov/files/document/mdpp-enrollment-tutorial-2024.pdf
- MDPP Enrollment Video: https://www.youtube.com/watch?v=S6FAJOLPsMo&feature=youtu.be
- MDPP Post-Enrollment Timeline: https://www.cms.gov/priorities/innovation/files/x/mdpp-enrollment-timeline.pdf
- Diabetes Self-Management Education and Support Services Organizations Fast-Tracking: https://www.cms.gov/files/document/mdpp-dsmes-enrollment-list.pdf


Medicare Diabetes Prevention Program (MDPP)
Enrollment Preparation Guide

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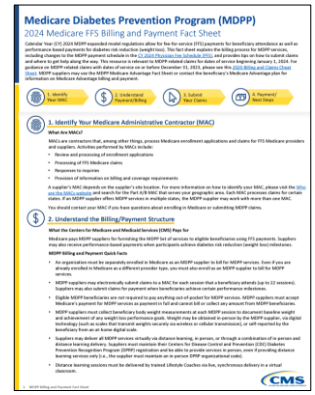
MDPP Billing and Claims Resources

- MDPP January 2024 Billing and Payment Webinar: https://www.cms.gov/files/document/mdpp-ffs-billing-payment-webinar-slides.pdf
- MDPP 2023-2024 Payment Transition Guidance: https://www.cms.gov/files/document/mdpp-2024-pymnt-transition.pdf
- MDPP 2024 Billing and Payment Factsheet: https://www.cms.gov/files/document/mdpp-ffs-bill-pay-fs-2024.pdf
- MDPP 2024 Billing and Payment Cheat Sheet: https://www.cms.gov/files/document/mdpp-billing-claims-cheat-sheet-2024.pdf
- MDPP Learning Activities Calendar: https://www.cms.gov/files/document/mdpp-learning-activies-calendar.pdf


Medicare Diabetes Prevention Program (MDPP)
2024 Medicare FFS Billing and Payment Fact Sheet

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Questions?

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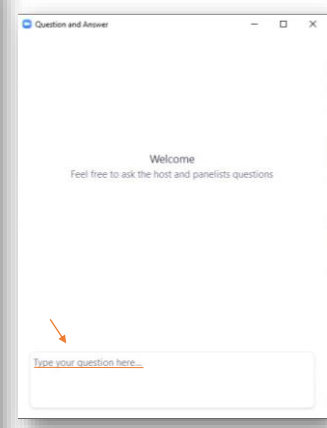

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Thank you!

- Contact us at ruralhealthinfo.org with any questions
- Please complete webinar survey
- Recording and transcript will be available on RHIhub website