Policy Update

CMS Releases CY 2024 Physician Fee Schedule Proposed Rule

On July 13, 2023, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2024 Revisions to Payment Policies Under the Physician Fee Schedule (PFS) and Other Revisions to Medicare Part B [CMS-1784-P] Proposed Rule, which includes proposals related to Medicare physician payment and the Quality Payment Program (QPP). Physicians and other clinicians are once again facing large, proposed cuts of more than 3.36% for CY 2024. While Congress has provided temporary partial fixes to physician payment in the last several years, its latest fix in the Consolidated Appropriations Act, 2023 (CAA, 2023), enacted at the end of 2022, does not offset all the proposed cuts in this rule. In all, the budget neutrality constraints of the fee schedule continue to result in a negative proposed conversion factor (CF) update. Beyond the cut to the CF, CMS proposes significant policies related to telehealth services, updates to the Medicare Shared Savings Program (MSSP), initiatives promoting health equity and other changes to further develop physician quality initiatives.

Key takeaways from the CY 2024 PFS Proposed Rule:

- *CF Reduction:* Proposes a 2024 CF of $32.7476, representing a 3.36% reduction from the 2023 physician CF of $33.8872, and a 2024 anesthesia CF of $20.4370, representing a 3.26% reduction from the 2023 anesthesia CF of $21.1249
- *Add-on Code for Complexity:* Would implement a new add-on code for complexity, G2211, that was previously finalized but delayed by Congress until 2024
- *Behavioral and Social Needs:* Outlines policies to promote behavioral healthcare and services addressing health-related social needs
- *Telehealth:* Proposes a new process for adding, removing or otherwise changing codes on the Medicare Telehealth Service list, and would create differential payment based on the place of service
- *Merit-Based Incentive Payment System (MIPS):* Would raise the MIPS performance threshold to 82 points in 2024, from 75 points in both 2022 and 2023
- *Appropriate Use Criteria (AUC) Program:* Would permanently sunset the AUC program
- *MSSP:* Proposes changes to the MSSP, including to the financial benchmarking methodology, assignment methodology and more.

Comments on the proposed rule are due on September 11, 2023.

Read on for a topline summary of the major provisions in the proposed rule.

- The proposed regulation is available here.
- The press release is available here.
- The fact sheet on payment policies is available here.
- The QPP factsheet is available here.
- The MSSP factsheet is available here.

PFS Major Payment Proposals

Conversion Factor

Medicare physician payment is based on the application of a dollar-based CF to geographically adjusted work, practice expense (PE) and malpractice relative value units (RVUs). Work RVUs capture the time, intensity and risk of the provider. PE RVUs capture the cost of supplies, equipment and clinical personnel wages used to furnish a specific service. Malpractice RVUs capture the cost of malpractice insurance.

Key Takeaway: CY 2024 CF would decrease to $32.7476, a reduction of more than 3.36%.

Medicare Physician Conversion Factor (2017–2024)		
Year	**CF**	**Actual Update (%)**
Jan 1, 2017	35.8887	0.24
Jan 1, 2018	35.9996	0.31
Jan 1, 2019	36.0391	0.11
Jan 1, 2020	36.0896	0.14
Jan 1, 2021	34.8931	-3.32
Jan 1, 2022	34.6062	-0.82
Jan 1, 2023	33.8872	-2.08
Jan 1, 2024	**32.7476**	**-3.36**

The 2024 proposed physician CF is **$32.7476**. This represents a decrease of approximately **3.36%** from the 2023 CF of $33.8872. The 2024 proposed anesthesia CF is **$20.4370**, which represents a decrease of approximately **3.26%** from the 2023 anesthesia CF of $21.1249.

The proposed update is primarily based on three factors: a statutory 0% update scheduled for the PFS in CY 2024[1], a negative 2.17% budget neutrality adjustment, and a funding patch passed by Congress at the end of CY 2022 through the CAA, 2023. This bipartisan legislation partially mitigated the CF cut by providing a 2.5% increase for the CY 2023 CF but only a 1.25% increase to offset part of the reduction to the CY 2024 CF. Separate from the PFS CF, the CAA, 2023, also waived the Pay-As-You-Go Act (PAYGO) 4% reduction for two years (2023 and 2024).

Cuts	Scheduled Cuts 2023	Net Effect with CAA 2023	Net Effect with CAA 2024
Medicare Physician CF Reduction	-4.47%	-2.08% (added 2.5%)	-3.36% (added 1.25%)
PAYGO Sequestration	-4%	0%	0%
TOTAL Cuts*	-8.47%	-2.08%	-3.36%

Note that the PAYGO reduction is only addressed for two years and will likely need to be considered again by Congress in 2025. There is also a 2% Medicare sequestration instituted by the Budget Control Act of 2011 that was temporarily halted during the COVID-19 public health emergency (PHE) but is now back in effect.

The overall negative adjustment to the 2024 CF reflects the more limited relief provided by Congress in

[1] The Medicare Access and CHIP Reauthorization Act of 2015 established a 0% update for PFS services through 2025. Beginning in 2026, clinicians identified as qualified participants in an Advanced Alternative Payment Model will receive an annual 0.75% update, and all other clinicians will receive a 0.25% annual update.

this year compared to 2023 and previous years[2] as well as a statutorily required negative 2.17% budget neutrality adjustment due to other spending increases. According to CMS, approximately 90% of the negative 2.17% budget neutrality adjustment is attributable to a new add-on code for complexity, G2211, with all other proposed valuation changes making up the other 10%. The new add-on code for complexity is described later in this summary.

These proposed payment reductions come at a time when physician practices, hospitals that employ physicians and other stakeholders are facing rising costs due to inflation, staffing shortages and significant challenges posed by other regulatory burdens (*e.g.*, prior authorization, interoperability requirements and participating in Medicare quality programs such as MIPS). In light of these burdens, the provider community likely will continue to press Congress for relief, although it is unclear if lawmakers are willing to fully offset the proposed payment reductions or seek other reforms, such as modifying the budget neutrality requirements. Lawmakers have introduced H.R. 2474, the Strengthening Medicare for Patients and Providers Act, which would provide a permanent annual update to the CF equal to the increase in the Medicare Economic Index; however, the cost of this legislation may be prohibitive to finding sufficient support to pass this bill. Accordingly, other reforms may be introduced or considered by Congress later this year.

Specialty Impact

Key Takeaway: Impact by specialty ranges from -4% to +3%.

Actual payment rates are affected by a range of proposed policy changes related to physician work, PE and malpractice RVUs. CMS summarizes the aggregate impact of these changes in Table 104 in the proposed rule. While impact on individual practices would vary based on service mix, the table provides insight into the overall impact of the policies in the rule for a specific specialty. Specialty impacts range from -4% for interventional radiology to +3% for endocrinology and family practice. Changes to the CF stemming from the CAA, 2023, fix are not reflected in the impact table. Thus, the actual impact on specialties would be approximately 1.25% lower than what is shown in Table 104.

Most of the differences in specialty impact result from proposed changes to individual procedures. The proposed implementation of the separate payment for the new add-on code for complexity, third year of the clinical labor pricing update, and proposed adjustments to certain behavioral health services led to relatively more positive impacts for family medicine, endocrinology, nurse practitioner, physician assistant, clinical social worker, psychiatry, clinical psychologist and general practice relative to all other specialties. Specialties that are negatively impacted by those same policies include anesthesiology, interventional radiology, radiology, vascular and thoracic surgery, physical/occupational therapy and audiologists.

[2] Congress intervened in 2020 with a provision in the CAA, 2021, that provided a one-year 3.75% positive adjustment for 2021 to partially offset CF cuts that were largely driven by payment increases to evaluation and management services. Congress intervened again in 2021 with a provision in the Protecting Medicare & American Farmers from Sequester Cuts Act that provided a one-year 3% positive adjustment to the CF for 2022. Essentially, the relief from Congress has waned over the years, leaving more negative updates for physicians and other clinicians.

Impact of proposed changes by selected specialties

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of Malpractice RVU Changes	Combined Impact
Family Practice	$5,504	2%	2%	0%	3%
Endocrinology	$507	1%	1%	0%	3%
Internal Medicine	$9,618	0%	1%	0%	1%
Nuclear Medicine	$51	-1%	-2%	0%	-3%
Radiology	$4,517	-1%	-2%	0%	-3%
Vascular Surgery	$1,009	0%	-3%	0%	-3%
Interventional Radiology	$457	-1%	-3%	0%	-4%

Note: Combined impact may not equal the sum of work, PE and malpractice as a result of rounding.
Source: Table 104, CY 2024 Proposed PFS, display copy.

Additional detail showing the facility/non-facility payment impact by specialty from the proposed changes can be found in Table 105.

Implementation of New Add-On Code for Complexity

Key Takeaway: CMS proposes to implement the new add-on code but revises utilization estimates.

In the CY 2021 PFS final rule, CMS implemented a new add-on code for complex patients, G2211, that could be reported with office and outpatient (O/O) evaluation and management (E/M) codes.[3] The primary policy goal of G2211 was to increase payments to primary care physicians and to reimburse them more appropriately for the care they provide to highly complex patients. CMS assumed that G2211 would be reported with 90% of all O/O E/M visits claims, which account for a significant portion (approximately 20%) of total PFS spending. Given this extremely high utilization assumption, G2211 had a significant effect on budget neutrality. Overall, G2211 accounted for an estimated increase in PFS spending of $3.3 billion and a corresponding 3.0% cut to the CY 2021 PFS CF. Because of the potential reduction in payments for physicians who do not typically bill O/O E/M visit codes, Congress delayed the implementation of G2211 until CY 2024. Since this policy was finalized in the CY 2021 PFS final rule and was simply delayed by Congress until CY 2024, the policy would automatically go into effect without any CMS action on January 1, 2024.

In this year's rule, CMS reaffirms that G2211 will go into effect as expected on January 1, 2024. However, CMS proposes to institute several policy refinements to G2211 that would result in a less significant negative budget neutrality adjustment. First, CMS would clarify that G2211 cannot be billed when the O/O E/M visit code is reported with payment modifier -25, which denotes a separately billable E/M service by the same practitioner furnished on the same day of a procedure or other service. CMS also revised its assumption for how often G2211 would be billed alongside an O/O E/M visit code. CMS received significant feedback on this assumption, with some arguing that many practitioners deliver care in settings designed to address acute conditions that do not require the type of care coordination and follow-up that G2211 is intended to capture. Further, CMS does not believe that G2211 should be reported if care is delivered by a provider that does not have an ongoing relationship with the patient. Considering stakeholder feedback, the uptake of new codes in prior years and the billing patterns of all

[3] G2211, Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed healthcare services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.

specialties, CMS significantly revises its previous 90% utilization assumptions in the proposed rule. CMS now estimates that G2211 would be billed with 38% of all O/O E/M visit claims initially. CMS estimates that when fully adopted after several years, G2211 would be billed with 54% of all O/O E/M visit claims.

Despite CMS decreasing its prior utilization assumption from 90% to 38% (and eventually 54%), G2211 would still drive a negative payment reduction to overall PFS spending for CY 2024. CMS notes that approximately 90% of the negative 2.17% budget neutrality adjustment to the PFS for CY 2024 is attributable to G2211. This policy would most negatively impact those specialties that do not routinely furnish O/O E/M visits and would therefore be unlikely to bill G2211.

In addition to making this proposal, CMS is interested in reviewing potential changes to how it establishes values for E/M and other services. CMS seeks comment about the potential range of approaches CMS could take to improve the accuracy of valuing services.

Practice Expense

Key Takeaway: CMS requests information on strategies for updates to PE data collection and methodology.

PE is the portion of the resources used in furnishing a service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages. CMS develops PE RVUs based on the direct and indirect practice resources involved in furnishing each service. Direct expenses include clinical labor, medical supplies and medical equipment. Indirect expenses include administrative labor, office expenses and all other expenses.

CMS continually works to improve the accuracy, predictability and sustainability of updates to the PE methodology with the goal of increased standardization and transparency for all PE inputs. In recent years, CMS has developed policies geared toward providing more consistent updates to the direct PE inputs, including supply/equipment pricing updates finalized in CY 2019 and clinical labor pricing updates finalized in CY 2022, both of which were phased in over four years. However, the indirect PE data inputs remain tied to legacy information primarily from the Physician Practice Information Survey (PPIS), which was most recently fielded by the American Medical Association (AMA) in 2007 and 2008 and reflects 2006 data. CMS believes that the indirect PE data inputs, like the direct PE data inputs, would benefit from a refresh that implements similar standard and routine updates in order to reduce the likelihood of unpredictable shifts in payment, especially when such shifts could be driven by the age of the underlying data rather than information about changes in actual costs.

Accordingly, in CY 2023 CMS issued a general comment solicitation to better understand how the agency might improve the collection of PE data inputs (including indirect PE inputs) and refine the PE methodology (including indirect PE allocation) for future rulemaking. In response to this request for feedback, many commenters urged CMS to continue to work with the AMA and various specialty societies involved in the previous PPIS data collection effort and wait for an updated set of PPIS data to become available for use before making changes that could result in a significant redistribution of value among PFS services and the specialties that furnish them. The AMA is currently in the process of updating the PPIS and expects to share results with CMS in advance of CY 2026 PFS rulemaking.

For CY 2024, CMS encourages interested parties to continue to provide feedback and suggestions to CMS that give an evidentiary basis to shape optimal PE data collection and methodological adjustments over time. CMS notes that such submissions could discuss the feasibility and burden of implementing any suggested adjustments and highlight opportunities to optimize the cadence, frequency and phase-in of any resulting adjustments. CMS would also like to understand whether, upon completion of the updated PPIS data collection effort by the AMA, contingencies or alternatives may be necessary to address lack of data availability or response rates for a given specialty, set of specialties or specific service suppliers that are paid under the PFS. CMS specifically seeks feedback on the following five

questions:

- Should CMS consider aggregating data for certain physician specialties to generate indirect allocators so that PE/HR calculations based on PPIS data would be less likely to over-allocate (or under-allocate) indirect PE to a given set of services, specialties or practice types. What thresholds or methodological approaches could be employed to establish such aggregations?
- Does aggregation of services, for purposes of assigning PE inputs, represent a fair, stable and accurate means to account for indirect PEs across various specialties or practice types?
- How should CMS balance factors that influence indirect PE inputs when these factors are likely driven by a difference in geographic location or setting of care, specific to individual practitioners (or practitioner types) versus other specialty/practice-specific characteristics (for example, practice size, patient population served)?
- What possible unintended consequences may result if CMS were to act on recommendations for any of highlighted considerations above?
- Do specific types of outliers or non-response bias require different analytical approaches and methodological adjustments to integrate refreshed data?

Clinical Labor Pricing Update

Key Takeaway: CMS proposes no modifications in year three of the clinical labor pricing update.
Beginning in CY 2019, CMS updated the supply and equipment prices used for PE as part of a market-based pricing transition. Updated supply and equipment prices were phased in over a period of four years; CY 2022 was the final year of this four-year transition. Beginning in CY 2022, and in conjunction with the final year of the supply and equipment pricing update, CMS updated the clinical labor prices used for PE based on Bureau of Labor Statistics data and other supplementary sources. Updated clinical labor prices are similarly being phased in over a period of four years; CY 2024 is the third year of this four-year transition.

Example of Clinical Labor Pricing Transition

Current Price	**$1.00**	
Final Price	**$2.00**	
Year 1 (CY 2022) Price	$1.25	1/4 difference between $1.00 and $2.00
Year 2 (CY 2023) Price	$1.50	1/3 difference between $1.25 and $2.00
Year 3 (CY 2024) Price	$1.75	1/2 difference between $1.50 and $2.00
Final (CY 2025) Price	$2.00	

Source: Table 4, CY 2024 Proposed PFS, display copy.

CMS did not receive new wage data or other additional information for use in clinical labor pricing from interested parties prior to the publication of the CY 2024 PFS proposed rule. CMS therefore proposes to continue using the clinical labor pricing that the agency finalized in the CY 2023 PFS final rule for CY 2024 ratesetting, incremented for year three of the update. As was the case for the market-based supply and equipment pricing update, the clinical labor rates will remain open for public comment over the course of the four-year transition period.

Rebasing and Revising the Medicare Economic Index

Key Takeaway: CMS proposes to continue to delay implementation of the 2017-based Medicare Economic Index (MEI) that was finalized in CY 2023.

The MEI measures the input price pressures of providing physician services looking at physicians' own time (compensation) and physicians' PEs. While the MEI is no longer directly used in calculating the annual update to the PFS CF, it continues to be used for the Medicare telehealth originating site facility fee, targeted medical review threshold amounts, rural health clinic payment limits, geographic practice cost index (GPCI) and other policies.

In CY 2023, CMS finalized, but delayed implementation of, a proposal to rebase and revise the MEI to reflect more current market conditions and practice costs using publicly available data. The current MEI weights reflect 2006 costs using data for self-employed physicians from the PPIS that the AMA conducted in 2007 and 2008. The AMA has not fielded another survey since 2006, although it is currently in the process of doing so, which means the MEI continues to reflect 2006-based costs. Because the finalized MEI changes are significant and would result in a substantial redistribution of PFS spending among specialties, CMS delayed implementation of this policy in CY 2023 and solicited comments on when and how to best incorporate these changes for future rulemaking.

In CY 2024, CMS proposes to continue to delay implementation of the 2017-based MEI that was finalized in CY 2023. As rationale for this proposal, CMS cites the AMA's ongoing data collection effort to update the PPIS and the significant redistributive impacts that MEI updates would have on PFS payments. CMS further notes that in CY 2023, it proposed to update the MEI based on 2017 Census Bureau data, which CMS believed was the most appropriate and recent data available. In the CY 2024 proposed rule, CMS notes that 2022 data will be available later this year and that the agency will monitor that data and any other data that become available related to physician services' input expenses. CMS states that it will propose any changes to the MEI, if appropriate, in future rulemaking.

Split (or Shared) Services

Key Takeaway: CMS would continue to delay the controversial policy of using time only for "substantive portion" definition in CY 2024.

CMS proposes to continue to allow providers to use the history, physical exam, medical decision making (MDM), or more than half of the total time spent with a patient to determine the substantive portion of split/shared E/M services in CY 2024.

In the CY 2022 PFS final rule, CMS finalized a policy for determining whether a physician or a non-physician practitioner should bill for an E/M service that both were involved in delivering (*i.e.*, a split/shared service). Under Medicare, a service can only be billed by one clinician, and if non-physician practitioners bill for a service, they only receive 85% of the total Medicare rate.

The finalized policy from the CY 2022 final rule applies only to E/M services delivered in facilities and excludes critical care. The major issue at hand is deciding who provides the "substantive" portion of the service. CMS decided to phase in the policy. In 2022, the history, physical exam, MDM or more than half of the total time spent with a patient could be used to determine the substantive portion of the split/shared service. However, going forward, only time would be used for the purposes of determining the substantive portion of a split/shared service.

Many physician specialty societies strongly oppose using only time to determine the substantive portion of a split/shared E/M service and formally requested that CMS reverse the 2023 policy and instead modify it to allow the determination to be made based on time or MDM. In last year's rule, CMS delayed implementation of the full transition to time only until 2024. CMS continued to allow providers to use the history, physical exam, MDM or more than half of the total time spent with a patient to determine the substantive portion of the split/shared service in 2023.

In this year's rule, CMS again proposes to delay the transition to time only and continue its current policy in 2024. This proposed additional delay would allow stakeholders another opportunity to comment on this policy. CMS is also interested in how facilities are currently implementing the delayed split/shared services policy. The AMA CPT Editorial Panel is revising aspects of shared or split visits that may impact its policies. CMS could consider whether a revision of the definition of substantive portion, in or beyond CY 2024, is needed through future rulemaking.

Potentially Misvalued Codes

Key Takeaway: CMS nominates 19 therapy codes as potentially misvalued and solicits comments on other potentially misvalued code nominations.

The Affordable Care Act mandates regular review of fee schedule rates for physician services paid by Medicare, including services that have experienced high growth rates. CMS established the potentially misvalued code process to meet this mandate. Codes that are identified for review under this process may eventually have their values increased, decreased or maintained.

For CY 2024, CMS received 10 nominations concerning various codes, including therapeutic apheresis, arthrodesis with imaging guidance, pulse oximetry for oxygen saturation and therapy codes. Of these codes, CMS nominated 19 therapy codes as potentially misvalued; these codes are included in Table 8 of the proposed rule. CMS also seeks comment on, but does not propose to nominate as potentially misvalued, the codes listed in the following chart.

Codes nominated as potentially misvalued that CMS does not propose to nominate but on which it seeks comment

Code	Descriptor
59200	Insertion cervical dilator (*e.g.*, laminaria, prostaglandin).
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device.
99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.
99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified healthcare professionals or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

Code	Descriptor
36514	Therapeutic apheresis; for plasma pheresis.
36516	Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion.
36522	Photopheresis, extracorporeal.
44205	Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy.
94762	Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure).
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (*e.g.*, by airflow or peripheral arterial tone), and sleep time.
0596T	Initial insertion of temporary valve-pump in female urethra.
0597T	Replacement of temporary valve-pump in female urethra.

Services Addressing Health-Related Social Needs and Behavioral Health

Key Takeaway: CMS proposes new codes and payment for community health integration (CHI) services, social determinants of health (SDOH) risk assessment and principal illness navigation (PIN) services provided by social workers, community health workers and other auxiliary personnel.

Practitioners are increasingly expending time and resources obtaining information from patients about health-related social needs and risks, and formulating diagnosis and treatment plans that take these needs into account. CMS notes that social workers, community health workers and other auxiliary personnel are currently performing some of these activities, and that the resources involved in these activities are not consistently appropriately reflected in current coding and payment policies.

Accordingly, CMS proposes new coding to describe and separately value three types of services that may be provided by auxiliary personnel incident to the billing physician or practitioner's professional services, and under the billing practitioner's supervision: CHI services, SDOH risk assessment and PIN services. CHI services address unmet SDOH needs that affect the diagnosis and treatment of the patient's medical problems. PIN services help people who are diagnosed with high-risk conditions (for example, mental health conditions, substance use disorder and cancer) identify and connect with appropriate clinical and support resources.

For SDOH risk assessments, CMS proposes a new stand-alone G code to recognize when practitioners spend time and resources assessing SDOH that may impact their ability to treat the patient. The SDOH risk assessment would be added to the annual wellness visit as an optional additional element with an additional payment. This code would also be added to the Medicare Telehealth Services List to accommodate a scenario in which the risk assessment is conducted in an interview format.

CMS proposes that CHI and PIN services could be furnished monthly following an initiating E/M visit (certain types of E/M visits, such as inpatient/observation, emergency room and skilled nursing facility visits, would not typically serve as CHI initiating visits because the practitioners furnishing the E/M services in those settings would not typically be the ones to provide continuing care to the patient). Similarly, CMS proposes that CHI services could not be billed while the patient is under a home health plan of care because of the significant overlap in services furnished in home health and CHI.

CMS seeks comment on the following issues:

- Whether any professional services other than an E/M visit performed by the billing practitioner as the prerequisite initiating visit for CHI or PIN services (including, for example, an annual wellness

visit) should be considered

- The typical duration of CHI and PIN services, in terms of the number of months for which practitioners furnish the services
- Where and how CHI, PIN and SDOH services are typically provided (*e.g.*, in-person, audio-video, two-way audio)
- If any other service elements that are part of associated care should be included in the CHI or PIN service codes
- Whether patient consent should be required for CHI or PIN services.

CMS notes that if the public response indicates that CHI services would frequently not involve direct contact with the patient or could extend for periods of time for which the patient might not be expecting to incur cost sharing obligations, CMS will consider requiring patient consent to receive CHI services in the final rule. CMS also seeks public comment on whether states typically cover services similar to CHI and PIN under their Medicaid programs and whether such coverage would be duplicative of the CHI or PIN service codes.

Behavioral Health

Key Takeaway: CMS proposes efforts to expand access to and address shortages of behavioral services and health providers.

CMS proposes to implement several provisions of the CAA, 2023, with the intent of encouraging and expanding access to behavioral health services. The rule would provide Medicare Part B coverage and payment for the services of marriage and family therapists (MFTs) and mental health counselors (MHCs). CMS proposes to allow addiction counselors that meet all the applicable requirements to be an MHC to enroll in Medicare as MHCs. The rule would also establish, as required by the CAA, 2023, new HCPCS codes under the PFS for psychotherapy for crisis services, and proposes to allow the Health Behavior Assessment and Intervention 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.

Lastly, CMS is looking at the valuation for timed behavioral health services under the PFS by applying an adjustment to the work RVUs for psychotherapy codes over a four-year transition. The rule seeks comment on ways to expand access to behavioral health services and information on digital therapies, including digital cognitive behavioral therapy.

Telehealth and Other Remote Services

The CAA, 2023, extends certain Medicare telehealth flexibilities related to the COVID-19 PHE through December 31, 2024. These waivers include flexibility related to where telehealth can be provided (*e.g.*, at home), which services can be provided (*e.g.*, expanded list of covered services) and the level of payment for these services (*e.g.*, allowing the higher non-facility rate for office-based physicians). This proposed PFS rule is the first since the COVID-19 PHE ended on May 11, 2023, and the agency's telehealth proposals have been highly anticipated.

Updates to the Telehealth Services List

Key Takeaway: CMS would change the structure of the Medicare Telehealth Services List.

CMS proposes to change the structure of the Medicare Telehealth Services List, which contains the telehealth service codes for which Medicare physicians can bill. Under current policy, Categories 1 and 2 are permanent, and Category 3 is temporary.[4] During the COVID-19 PHE, CMS used a combination of PHE-related authority and statutory authority to add codes to the Medicare Telehealth Services List on a temporary basis, some of which fell under Category 3. Since the PHE ended, CMS no longer has the same regulatory flexibilities to maintain a temporary list. The agency acknowledges that it has become challenging for stakeholders to understand the Medicare Telehealth Services List, its categories, and which codes are permanent, and which are temporary. Therefore, CMS proposes to eliminate the use of Categories 1–3 and change to a "permanent" and "provisional" approach.

CMS proposes the following new steps for adding, removing or changing the status of services on the Medicare Telehealth Services List on a permanent basis:

1. Determine whether the service is separately payable under the PFS.
2. Determine whether the service is subject to the provisions of section 1834(m) of the Social Security Act, which means when at least some elements of the service, when delivered via telehealth, are a substitute for an in-person, face-to-face encounter, and all of those face-to-face elements of the service are furnished using an interactive telecommunications system.
3. Review the elements of the service as described by the HCPCS code and determine whether each of them is capable of being furnished using an interactive telecommunications system.
4. Consider whether the service elements of the requested service map to the service elements of a service on the list that has a permanent status described in previous final rulemaking.
5. Consider whether there is evidence of clinical benefit analogous to the clinical benefit of the in-person service when the patient, who is located at a telehealth originating site, receives a service furnished by a physician or practitioner located at a distant site using an interactive telecommunications system.

To provide a transition period for this new process, CMS proposes to move all codes currently in Categories 1 and 2 to the "permanent" list. Any codes added on a "temporary Category 2" or a Category 3 basis would be placed on the "provisional" list. There is currently no specified timeframe to remove "provisional" codes from the list. Under the agency's proposal, a provisional status would be assigned for codes that satisfy the proposed threshold steps (steps 1, 2 and 3 mentioned above). CMS indicates in the proposal that it would not assign provisional status when it is improbable that the code would ever achieve permanent status, and that the agency would revisit provisional status through the regular annual submissions and rulemaking processes where a submission provided new evidence, where the agency's claims monitoring showed anomalous activity, or as indicated by patient safety considerations.

Stakeholders will likely appreciate that the agency does not propose to remove any codes during CY 2024. While this proposal does attempt to simplify the process, stakeholders should look at the new stepwise process to determine if the agency is considering the appropriate metrics for analyzing potential permanent or provisional codes.

Telehealth Reimbursement

Key Takeaway: CMS proposes permanent facility rates for certain place of service (POS) codes.
The POS is used to determine whether a service is paid using the facility or non-facility rate. Under the PFS, there are two payment rates for many physicians' services: the facility rate, which applies when the service is furnished in a facility such as a hospital or skilled nursing facility setting, and the non-facility

[4] Category 3 includes codes for which there is likely to be clinical benefit when furnished via telehealth, but there is not yet sufficient evidence available to add the services permanently to the list. Services added to the Medicare Telehealth Services List on a temporary Category 3 basis would ultimately need to meet the Category 1 or 2 criteria in order to be added to the Medicare Telehealth Services List on a permanent basis.

rate, which applies when the service is furnished in an office or other setting. The PFS facility rate is a separate payment to the facility (hospital or skilled nursing facility), often referred to as a "facility fee," that is made under other payment systems, reflects the facility's costs associated with the service (clinical staff, supplies, equipment, overhead) and is paid in addition to what is paid to the professional under the PFS.

During the PHE, CMS provided temporary policies that allowed physicians and practitioners who billed for Medicare telehealth services to report the POS code that they would have reported had the service been furnished in-person. In an attempt to continue equitable payment for in-person and virtual services and to collect data on telehealth utilization and billing practices, CMS also created a CPT telehealth modifier (95) that was applied to claim lines that describe services furnished via telehealth during the PHE. The POS code was reported where the service would have occurred had it not been furnished via telehealth. This allowed telehealth services to be paid at the PFS non-facility rate.

In CY 2023, CMS stated that following the end of the calendar year in which the PHE ends, physicians and practitioners would no longer bill claims with the 95 modifier along with the POS code that would have applied had the service been furnished in person. Instead, in CY 2023, CMS finalized two POS codes for telehealth services:

- POS 02, redefined as Telehealth Provided Other than in Patient's Home (Descriptor: The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.)
- POS 10, Telehealth Provided in Patient's Home (Descriptor: The location where health services and health-related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health-related services through telecommunication technology.)

CMS proposes that beginning in CY 2024, claims billed with POS 02 (Telehealth Provided Other than in Patient's Home) would continue to be paid at the lower PFS facility rate. Claims billed with POS 10 (Telehealth Provided in Patient's Home) would be paid at the higher PFS non-facility rate.

CMS believes that this proposal reflects the trends of telehealth data over the past several years. The agency took note of the patterns of behavioral and mental health providers specifically, discussing how many of these providers are now seeing patients in office settings as well as via telehealth, resulting in a continued office presence even as a significant proportion of their visits are telehealth. The agency believes the PEs are more accurately reflected by the non-facility rate. Similarly, CMS continues to believe that telehealth services provided when patients are not in their homes (billed with POS 02) should be paid at the PFS facility rate, as this more accurately reflects the PEs of these telehealth services.

CMS indicates that this policy is not expected to impact or significantly change the utilization of telehealth under Medicare, as it largely reflects how CMS was paying for the majority of services during the PHE policies.

Stakeholders may want to take a close look at data to ensure this approach will not lead to disruptions in care and access to telehealth services, or otherwise impact providers' and practices' approach to in-person and virtual care.

Alignment of CAA, 2023, Extension of Medicare Telehealth Flexibilities

In the proposed rule, CMS would align PFS payment policies with the extension of Medicare telehealth flexibilities as provided through the CAA, 2023. This effectively means that CMS proposes that the

following policies remain in place through January 1, 2025:

- Delaying the in-person requirement for mental health telehealth, including services furnished at rural health clinics (RHCs) and federally qualified health centers (FQHCs) (*i.e.*, the requirement for an in-person visit with the physician or practitioner within six months prior to the initial mental health telehealth service)
- Expanding originating sites to include where the beneficiary is located at the time of the telehealth services, including an individual's home
- Expanding the list of eligible telehealth practitioners to include occupational therapists, speech language pathologists and qualified audiologists (the list is the same as finalized in the CY 2023 final rule)
- Coverage of audio-only services for services on the Medicare Telehealth Service List.

The CAA, 2023, also added MFTs and MHCs to the list of eligible practitioners. These professionals would be added permanently beginning January 1, 2024.

Other Temporary Extensions
CMS proposes to continue other flexibilities on a temporary basis. The agency would continue to evaluate these through CY 2024 and reassess in subsequent rulemaking. These flexibilities include the following:

- **Removal of frequency limitations.** CMS proposes to continue its suspension of frequency limitations for certain subsequent inpatient visits, subsequent NF visits and critical care consultations furnished via Medicare telehealth.
- **Direct supervision.** CMS proposes to maintain its current definition of direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications.
- **Supervision of residents in teaching settings.** CMS proposes to continue to allow the teaching physician to have a virtual presence in all teaching settings only in clinical instances when the service is furnished virtually (for example, a three-way telehealth visit, with all parties in separate locations). This would permit teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment is sought through audio/video real-time communications technology for all residency training locations.

Taken together, these proposed changes would be continued progress toward wider adoption and utilization of telehealth for Medicare providers and beneficiaries in a post-PHE regulatory environment. However, uncertainty remains regarding how CMS would address these issues if many of the current Medicare telehealth flexibilities end on December 31, 2024 (as currently slated through the CAA, 2023).

Remote Monitoring Policies

Key Takeaway: CMS proposes clarifications on remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) policies and seeks input from stakeholders on current payment policies.

In recent years, CMS has established payment for several RPM and RTM codes. These codes generated a significant level of stakeholder interest even prior to the pandemic. During the COVID-19 PHE, CMS implemented flexibilities to allow for broader use of these services but provided limited guidance on how these services should be reported. Industry stakeholders expected a significant increase in use of these codes and anticipated that CMS might propose additional policies to further clarify and potentially limit the use of these codes. While utilization for the RPM codes again increased, CMS does not propose any policy changes specific to the RPM and RTM codes.

CMS notes that it has many questions regarding billing scenarios and the appropriate reporting of codes.

In an effort to broadly share these clarifications with stakeholders, CMS discusses potential clarifications on the following topics:

- Requirement that RPM services are only furnished to established (as opposed to new) patients
- Requirement that following the conclusion of the COVID-19 PHE, the 16-day data collection requirement (as opposed to the two-day data collection requirement) is reinstated
- Services with which RPM or RTM services can be furnished
- Scenarios where RPM or RTM may be separately reimbursable during the global period.

In response to requests from stakeholders, CMS proposes to pay for RPM and RTM services furnished in FQHCs and RHCs. Specifically, CMS proposes to allow for services described by these services to be reported by FQHCs and RHCs under the general care management code, G0511 (FQHC or RHC only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, nurse practitioner, physician's assistant or certified nurse's assistant), per calendar month). This proposal is consistent with recent FQHC and RHC policies by CMS to improve care management in these settings. To account for this proposed policy, CMS proposes to adjust the reimbursement rate for G0511 by taking a weighted average utilization of all services that could be reported under this HCPCS code.

The proposed rule also addresses RTM services for physical and occupational therapists in private practices that would allow for general rather than direct supervision of therapy assistants. CMS requests comments on whether to allow the general supervision policy to apply for all services, not just for RTM services.

Finally, as part of a broader request for information on digital therapies, CMS seeks input from stakeholders to better understand the current opportunities and challenges related to existing coverage and payment policies for RPM and RTM. The agency intends to consider the feedback it receives as it contemplates additional provider education, program guidance and possible future rulemaking on these services. Key questions on RPM and/or RTM include the following:

- What practitioners and auxiliary staff are involved in furnishing RPM and RTM services, including training patients on its use? To what extent is additional training or supervision of auxiliary staff necessary to provide an appropriate and/or recommended standard of care in the delivery of these services?
- How are data that are collected by the technology maintained for recordkeeping and care coordination?
- What information exists about how an episode of care should be defined, particularly in circumstances when a patient may receive concurrent RTM or digital cognitive behavioral therapy services from two different clinicians engaged in separate episodes of care?
- How might allowing multiple concurrent RTM services for an individual beneficiary affect access to healthcare, patient out-of-pocket costs, the quality of care, health equity and program integrity?
- What are the advantages and disadvantages of a generic RTM device code versus specific RTM codes? If a generic code was created, how should CMS consider pricing it given the array of pricing models used for RPM and RTM services?

CMS also poses additional questions in this request for information specific to digital cognitive behavioral therapy and other digital therapeutics.

Quality Payment Program

Under the QPP, eligible clinicians can be subject to payment adjustments based upon performance under MIPS, or they can participate in the Advanced Alternative Payment Model (APM) track. Eligible clinicians in MIPS will have payments increased, maintained or decreased based on relative performance in four categories: Quality, Cost, Promoting Interoperability and Improvement Activities. Eligible clinicians participating in an Advanced APM are exempt from MIPS and previously qualified for a 5% bonus payment. After the 5% bonus expired, Congress reauthorized the bonus at only 3.5% for 2023. CMS has also implemented a new alternative to traditional MIPS, called the MIPS Value Pathways (MVPs), as a voluntary option.

QPP: Merit-Based Incentive Payment System

Key Takeaway: CMS proposes to increase the program threshold required to avoid a MIPS penalty and receive a positive payment adjustment.

To avoid a negative adjustment and be eligible for a positive payment adjustment, a provider's MIPS total score must reach a performance threshold. CMS proposes to increase the 2023 MIPS performance threshold of 75 points to 82 points for the 2024 performance period, creating a more challenging program for participants. Historically, CMS had increased the MIPS performance threshold, but during the COVID-19 PHE, the agency maintained a 75-point threshold for two consecutive years, allowing MIPS participants to avoid additional quality reporting challenges. The agency could still change the threshold in the final rule and in future years as the program continues to develop.

When setting the performance threshold, CMS previously looked at the mean score from a single performance period. In this proposed rule, CMS now reviews a "prior period" to establish the performance threshold, defined as three performance periods. Accordingly, for the CY 2024 performance period/2026 MIPS payment year, CMS proposes to use performance spanning the CY 2017/2019 MIPS payment year through CY 2019 performance period/2021 MIPS payment year. As shown in the table below, CMS could have considered alternative performance thresholds ranging from 75 points to as high as 89 points.

TABLE 51: Possible Values for the CY 2024 Performance Period/2026 MIPS Payment Year Performance Threshold

2017 Performance Period	2018 Performance Period	2019 Performance Period	2020 Performance Period	2021 Performance Period	2017–2019 Performance Period
74.65	87.00	85.63	89.47	89.22	82.06

CMS also seeks comment on how it can improve MIPS performance, including for participants who are already high-performers. CMS is concerned that participants may repeatedly choose the same measures and activities on which they are confident they will perform well. To address this issue, CMS is considering modifying scoring policies to encourage clinicians who have consistently been high performers in MIPS to continuously improve various areas of their clinical practice, which may include requiring more rigorous performance standards, emphasizing year-to-year improvement in the performance categories, or requiring that eligible clinicians report on different measures or activities once they have demonstrated consistently high performance on certain measures and activities.

Key Takeaway: CMS proposes to continue refining measures within the MIPS categories.

The MIPS performance category weights are specified in statute, are not open for comment and have not changed from the previous year.

Performance Category	PY 2023 Weight	PY 2024 Proposed Weight
Quality	30%	30%
Cost	30%	30%
Promoting Interoperability	25%	25%
Improvement Activities	15%	15%

Quality Category

CMS proposes changes that would result in a total of 200 quality measures in its quality inventory. Specific measures are outlined in more detail in the QPP fact sheet and include the addition of 14 measures, removal of 12 quality measures (see Appendix C), partial removal of three quality measures from the MIPS quality measure inventory (proposed for removal for traditional MIPS and retained for MVP use only) (See Appendix D) and substantive changes to 59 existing quality measures.

CMS proposes to maintain the data completeness criteria threshold of at least 75% for the CY 2026 performance period/2028 MIPS payment year and increase the data completeness criteria threshold to at least 80% for the CY 2027 performance period/2029 MIPS payment year.

Other proposed quality changes include a new requirement to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for MIPS Survey in Spanish.

Cost Category

CMS proposes to add five new episode-based measures to the cost performance category beginning with the CY 2024 performance period. The measures are related to depression, emergency medicine, heart failure, low back pain, and psychoses and related conditions. The agency proposes to remove the Simple Pneumonia with Hospitalization episode-based measure beginning with the CY 2024 performance period.

In previous rulemaking, CMS established that the MIPS cost category would include improvement scoring to reward participants that showed progress. While the maximum cost improvement score was zero percentage points for the 2020 through 2024 MIPS payment years, CMS proposes to start with a one percentage point improvement score beginning with the 2025 MIPS payment year. Improvement would be calculated at the category level without using statistical significance.

Improvement Activities

CMS proposes to add five, modify one and remove three improvement activities from the improvement activities inventory (see Appendix E). These proposals include an MVP-specific improvement activity titled Practice-Wide Quality Improvement in MIPS Value Pathways that would allow clinicians to receive full credit in this performance category.

Promoting Interoperability

CMS proposes the following:

- Lengthening the performance period for this category from 90 days to 180 days
- Modifying one of the exclusions for the Query of Prescription Drug Monitoring Program measure
- Providing a technical update to the ePrescribing measure
- Modifying the Safety Assurance Factors for Electronic Health Record Resilience (SAFER) Guide measure to require MIPS eligible clinicians to affirmatively attest to completion of the self-

assessment of their implementation of safety practices

- Continuing to reweight this performance category at 0% for clinical social workers for the CY 2024 performance period/2026 MIPS payment year.

In the past, CMS allowed certain participants to not be scored in the promoting interoperability category and re-weight the other MIPS categories. CMS proposes not to continue this automatic reweighting for physical therapists, occupational therapists, qualified speech-language pathologists, clinical psychologists, and registered dietitians and nutrition professionals for the 2024 performance period.

Data Submission

To submit MIPS data, clinicians currently can use health information technology (IT) vendors or qualified clinical data registries (QCDRs) and qualified registries. Because of concerns over inaccurate data submission, CMS proposes to eliminate the health IT vendor category beginning with the CY 2025 performance period. Health IT vendors would still be able to participate in MIPS as third-party intermediaries by self-nominating to become a qualified registry or QCDR (if requirements are met) but could no longer automatically provide MIPS data submission.

Public Reporting

CMS uses its Compare websites to publicly report performance data. To improve procedure utilization data on individual clinician profile pages, CMS proposes to incorporate Medicare Advantage encounter data for a more accurate representation of procedure volumes. CMS also continues to signal its intent to begin publicly reporting cost measures, beginning with the CY 2024 performance period/2026 MIPS payment year, and includes a request for information seeking comment on potential approaches to, and considerations for, public reporting.

QPP: MIPS Value Pathways

Key Takeaway: CMS proposes five new MVPs.

The MVPs are a participation option to motivate clinicians to move away from reporting on self-selected activities and measures (traditional MIPS) and towards an aligned set of measure options designed to be meaningful to patient care, better connect measures across MIPS categories and be more relevant to a clinician's scope of practice. Over the years, participation in traditional MIPS has been criticized as expensive and time consuming with low positive payment adjustments as a reward, and as having an uncertain impact on patient care. At the same time, some stakeholders have raised concerns about sunsetting MIPS because MVPs are untested, and it is unclear whether there will be MVP options for all participants. In the CY 2022 final rule, CMS finalized a proposal to launch the MVPs in 2023, set an implementation timeline and defined MVP criteria. CMS then launched the option for MVPs with 12 different pathways[5] reflecting various specialties and care settings. CMS estimates that for the 2024 performance period, approximately 14% of eligible clinicians will participate in MVP reporting.

In this rule, CMS outlines the following MVP proposals:

- Establishing five new MVPs on the topics of Women's Health; Infectious Disease, Including Hepatitis C and HIV; Mental Health and Substance Use Disorder; Quality Care for Ear, Nose and Throat (ENT); and Rehabilitative Support for Musculoskeletal Care

[5] The 12 MVPS previously established by CMS are Advancing Cancer Care; Optimal Care for Kidney Health; Optimal Care for Patients with Episodic Neurological Conditions; Supportive Care for Neurodegenerative Conditions; Promoting Wellness; Advancing Rheumatology Patient Care; Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes; Advancing Care for Heart Disease; Optimizing Chronic Disease Management; Adopting Best Practices and Promoting Patient Safety within Emergency Medicine; Improving Care for Lower Extremity Joint Repair; Patient Safety and Support of Positive Experiences with Anesthesia.

- Consolidating the Promoting Wellness and Managing Chronic Conditions MVPs into a single primary care MVP
- Modifying the 12 previously finalized MVPs.

Therefore, MVP participants would have a total of 16 MVPs available for the CY 2024 performance period/2026 MIPS payment year.

MVP Implementation Timeline: The MVP program remains a voluntary option, to provide time for MIPS eligible clinicians to familiarize themselves with MVPs and begin preparing their practices for participation. In other documents and presentations, CMS has suggested that it will eventually sunset MIPS and move clinicians to MVPs but has moved away from an explicit date for this transition to occur.

Some stakeholders may raise concerns about whether MVPs are enough of a departure from the current program and whether there will be MVP options for all participants and specialties. Of interest will be which physicians and entities choose to move forward with the MVPs in 2024 and how fast the transition away from traditional MIPS will occur.

Advanced APM Track

Key Takeaway: CMS proposes policies that it believes will "encourage broad clinician participation in Advanced APMs," including calculating the qualifying APM participant (QP) determinations at the individual level rather than at the entity level. CMS proposes codifying certain sections of the CAA, 2023, that extend the Advanced APM bonus and freeze the QP thresholds. However, without further congressional action, the bonuses will expire and the QP thresholds will increase in performance year 2024.

Incentive Payments: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) included a 5% incentive payment for clinicians participating in advanced APMs through the 2022 performance year/2024 payment year. In performance year 2024/payment year 2026, MACRA also provides for two different CFs depending on advanced APM participation: eligible clinicians who are qualifying participants in Advanced APMs will receive a differentially higher 0.75% update to the CF compared to the 0.25% update to the general CF each year.

In December 2022, Congress extended availability of the advanced APM incentive payment for one year, allowing eligible clinicians to receive a 3.5% (down from the 5%) incentive payment in the 2023 performance year/2025 payment year. The extension avoided a one-year gap in which there would otherwise have been no statutory payment incentive to participate in an advanced APM.

CMS has previously noted its concern with the structure of the MACRA payment system. Even accounting for the incentive payment extension and for the CF differential, clinicians might receive higher payments through MIPS (potentially incentivizing clinicians to shift into MIPS and out of advanced APMs). In last year's rule, CMS sought feedback on whether administrative action would be needed to continue to incentivize advanced APM participation. In this proposed rule, CMS would amend existing regulations to reflect the one-year extension of the incentive payment. While CMS does not expressly request stakeholder input on the adequacy of incentives for advanced APM participation in the proposed rule, this will likely remain an important issue for advanced APM participants after the one-year extension of the incentive payments expires.

QP Determinations: In order to qualify for an advanced APM bonus, clinicians must provide at least a certain percentage of their payments or care for a certain percentage of their patients through the advanced APM (discussed in more detail below). If clinicians meet this threshold, they are called QPs. Since the inception of the QPP, QP status has been determined at the advanced APM entity level rather than at the individual clinician level. When CMS created the policy, the agency believed that this could lead to some eligible clinicians becoming QPs when they would not have met the QP threshold individually (a "freerider" scenario) or, conversely, some eligible clinicians not becoming QPs within an

advanced APM entity when they might have qualified individually (a dilution scenario). However, CMS also believed that the benefits of performing QP determinations for the APM entity as a group outweighed these potential scenarios. Over the last few years, CMS has heard that this policy may have inadvertently discouraged some APM entities from including certain types of eligible clinicians, particularly in multi-specialty APM entities such as accountable care organizations (ACOs), leading those clinicians to be excluded from participation in advanced APMs. Since patients are attributed to many advanced APMs based on the care provided by primary care providers, some advanced APM entities may want to exclude specialists who furnish relatively fewer services that lead to attribution in order to meet the QP threshold. Thus, CMS has reconsidered its current policy to make most QP determinations at the APM entity level and instead proposes that, beginning with the QP performance period for CY 2024, it would make all QP determinations at the individual level.

QP Thresholds: The QP thresholds are determined by law. The CAA, 2023, extended the QP thresholds of 50% for the payment amount method and 35% for the patient count method through performance year 2023 (payment year 2024). However, starting in performance year 2024 (payment year 2026), the QP thresholds are set to increase to 75% for the payment amount method and 50% for the patient count method.

Medicare Shared Savings Program

Proposals for the MSSP further advance CMS's value-based care strategy for growth, alignment and equity while responding to ACOs' policy concerns. CMS proposes changes to continue to move ACOs toward a digital measurement of quality by establishing a new Medicare Clinical Quality Measure (CQM) collection type for ACOs under the APM Performance Pathway (APP).

CMS also proposes updates to the benchmarking methodology (for agreement periods beginning on January 1, 2024) to further mitigate the impact of the negative regional adjustment and to encourage participation by ACOs caring for medically complex, high-cost beneficiaries. CMS proposes to update the step-wise beneficiary assignment methodology to provide greater recognition of the role of nurse practitioners, physician assistants and clinical nurse specialists in delivering primary care services. CMS also proposes several refinements to the Advance Investment Payments (AIP) that qualifying ACOs can receive to help with the significant costs associated with starting an ACO.

CMS seeks stakeholder feedback on potential future MSSP developments, including adding a potential new track that would offer a higher level of risk and reward than currently available under the ENHANCED track, refining the three-way blended benchmark update factor and the prior savings adjustment, and promoting enhanced collaboration between ACOs and community-based organizations. Overall, CMS expects that these proposals will increase MSSP participation by approximately 10% to 20%, advancing CMS's stated goal of having all beneficiaries in a care relationship with accountability for quality and total cost of care by 2030. Key proposals are outlined below.

Key Takeaway: CMS would update the MSSP eligibility criteria.

CMS proposes modifications to the MSSP eligibility requirements, including governance requirements and determinations of an ACO's level of experience in performance-based risk, as follows:

- **Removing the governance exception.** In 2011, CMS established requirements for the composition and control of an MSSP ACO's governing body, including a requirement that at least 75% control must be held by ACO participants. CMS also established an option for ACOs to seek an exception to this governance requirement. CMS now proposes to remove the option for ACOs to request an exception, stating that the 75% participant control threshold is critical to ensuring that governing bodies are participant-led and best positioned to meet program goals while allowing for

partnerships with non-Medicare-enrolled entities to provide needed capital and infrastructure for ACO formation and administration.

- **Determining ACO experience.** CMS proposes to codify an existing operational approach in determining an ACO's level of experience to specify that CMS considers that an ACO participant TIN has participated in a performance-based risk Medicare ACO initiative if it was included on a participant list used in financial reconciliation for a performance year under performance-based risk during the five most recent performance years.

Key Takeaway: CMS proposes several updates to the quality performance standard.
CMS proposes revisions to the MSSP quality reporting and quality performance requirements. Additional information on the CY 2024 Quality Payment Program proposed changes is available here. Key proposals include the following:

- **Medicare CQMs.** CMS proposes to allow MSSP ACOs the option to report quality measures under the APP on only their Medicare beneficiaries through Medicare CQMs, to help ACOs build the infrastructure, skills, knowledge and expertise necessary to report the all payer/all patient MIPS CQMs and electronic CQMs (eCQMs). CMS proposes to use the MIPS data completeness criteria thresholds for Medicare CQMs (establishing data completeness at 75% for the CY 2024, CY 2025 and CY 2026 performance periods, and at 80% for the CY 2027 performance period). Benchmarks for scoring ACOs on the Medicare CQMs would be developed in alignment with MIPS benchmarking policies. ACOs would continue to have the option to report quality data utilizing the CMS Web Interface measures, eCQMs and/or MIPS CQMs collection types. In performance year 2025 and subsequent performance years, ACOs would have the option to report quality data utilizing the eCQMs, MIPS CQMs and/or Medicare CQMs collection types. ACOs that report Medicare CQMs would be eligible for the health equity adjustment to their quality performance category score when calculating shared savings payments.

- **Health equity adjustment underserved multiplier.** CMS proposes to revise the calculation of the health equity adjustment underserved multiplier. CMS proposes to modify the calculation of the proportion of assigned beneficiaries dually eligible for Medicare and Medicaid and the calculation of the proportion of assigned beneficiaries enrolled in the Medicare Part D low-income subsidy (LIS) to use the number of beneficiaries rather than person-years to calculate the proportion of the ACO's assigned beneficiaries who are enrolled in LIS or who are dually eligible for Medicare and Medicaid. This policy change would include beneficiaries with partial-year LIS/dual-eligible enrollment, recognizing more beneficiaries as underserved.

- **Use of historical data for MIPS quality performance category score.** CMS proposes to use historical data to establish the 40th percentile MIPS quality performance category score used for the quality performance standard. CMS proposes to use a rolling three-performance-year average, with a lag of one performance year. For example, the 40th percentile MIPS quality performance category score, used for the quality performance standard for performance year 2024, would be based on averaging the 40th percentile MIPS quality performance category scores from performance years 2020 through 2022. This approach would allow CMS to provide MSSP ACOs with the quality performance standard they must meet in order to share in savings at the maximum sharing rate prior to the start of the performance year.

- **Scoring policy for excluded APP measures.** CMS proposes to apply an MSSP scoring policy for excluded APP measures. CMS proposes that (1) if an ACO reports all required measures under the APP, meets the data completeness requirement for all required measures, and receives a

MIPS quality performance category score, and (2) if the ACO's total available measure achievement points used to calculate the ACO's MIPS quality performance category score for the performance year is reduced due to measure exclusion, CMS will use the higher of the ACO's health equity adjusted quality performance score or the equivalent of the 40th percentile MIPS quality performance category score across all MIPS quality performance category scores (excluding entities/providers eligible for facility-based scoring) to determine whether the ACO meets the quality performance standard required to share in savings at the maximum rate under its track (or payment model within a track) for the relevant performance year.

- **Certified electronic health record technology (CEHRT) requirements.** CMS proposes to align CEHRT requirements for MSSP ACOs with MIPS. CMS proposes to remove the MSSP CEHRT threshold requirements beginning in performance year 2024, and to add a new requirement (for performance years beginning on or after January 1, 2024) that all MIPS eligible clinicians, QPs and partial QPs participating in the ACO, regardless of track, must report the MIPS Promoting Interoperability performance category measures and requirements to MIPS at the individual, group, virtual group or APM level, and earn a MIPS performance category score.

- **MVP reporting for specialists.** CMS solicits stakeholder feedback on MVP reporting for specialists in MSSP ACOs. CMS seeks comments on potential future scoring incentives that could be applied to an ACO's health equity adjusted quality performance score when specialists who participate in the ACO report quality MVPs.

- **Case minimum requirement.** CMS proposes to replace references to meeting the case minimum requirement with the requirement that the ACO receive a MIPS quality performance category score in order to meet the quality performance standard. CMS states that this change is intended to correct the purpose of references to case minimums by incorporating all of the applications of case minimums in the MIPS quality performance category scoring policies to determine an ACO's quality performance standard under MSSP.

Key Takeaway: CMS proposes key changes to the assignment methodology.
Notable proposed revisions to the MSSP assignment methodology include the following:

- **Window for assignment.** CMS proposes to use an expanded window for assignment in a new step three to the claims-based alignment process in order to identify additional beneficiaries for ACO assignment.

- **Assignable beneficiary.** CMS proposes to modify the definition of "assignable beneficiary" to be consistent with this expanded window.

- **New definitions.** CMS proposes to add a new definition of "expanded window for assignment" to mean the 24-month period used to assign beneficiaries to an ACO, or to identify assignable beneficiaries, or both, that includes the applicable 12-month assignment window and the preceding 12 months.

The new step three would apply only to beneficiaries who received at least one primary care service during the expanded window for assignment from an ACO professional who is a primary care physician or who has one of the specialty designations outlined in 42 CFR 425.402(c). The proposal seeks to better account for beneficiaries who may receive primary care from non-physician practitioners (*e.g.*, nurse practitioners, physician assistants, clinical nurse specialists) during the 12-month assignment window, but who received care from a physician in the preceding 12 months. Beneficiaries who do not receive any primary care services during the assignment window would continue to be excluded from claims-based

alignment. If finalized, these changes would be effective for the performance year beginning on January 1, 2025.

CMS believes that the use of an expanded window for assignment could result in a larger assignable population, including a greater number of beneficiaries from underserved populations. CMS seeks comment on the proposed revisions to the definitions of assignable beneficiary and assignment window, as well as the new definition of expanded window for assignment and the length of the expanded window.

Key Takeaway: CMS proposes several updates to the benchmarking methodology.
For ACOs in agreement periods beginning on January 1, 2024, and beyond, CMS proposes a number of refinements to the financial benchmarking methodology, including the following:

- **Regional service area risk score growth.** CMS proposes to cap the risk score growth in an ACO's regional service area when calculating regional trends used to update the historical benchmark at the time of financial reconciliation.
- **Benchmark risk adjustment.** CMS proposes to apply the same CMS-HCC risk adjustment methodology applicable to the calendar year corresponding to the performance year in calculating risk scores for Medicare fee-for-service beneficiaries for each benchmark year (*i.e.*, applying the same model used in the performance year for all benchmark years).
- **Negative regional adjustment.** CMS proposes to mitigate the impact of the negative regional adjustment on the benchmark.
- **Prior savings adjustments.** CMS specifies the conditions under which CMS could recalculate the prior savings adjustment for changes in values used in benchmark calculations due to compliance action taken.

CMS seeks comment on the proposed changes to calculating the regional component of the update factor, adjustments to the historical benchmark, the prospective HCC risk scores to be used in risk adjustment for purposes of benchmark calculations, and more.

Key Takeaway: CMS proposes to refine the AIP policies.
In last year's rule, CMS finalized a new payment option for eligible MSSP ACOs (entering agreement periods beginning on or after January 1, 2024) to receive advance shared savings payments, referred to as AIP, to help with the significant costs associated with starting an ACO. The AIP allows low-revenue ACOs that are new to MSSP and are inexperienced with performance-based risk to receive advance payment of their shared savings for the first two years of their five-year agreement period. AIP includes a one-time fixed payment of $250,000 and quarterly payments based on risk factors of the ACO's beneficiary population. Key refinements to the AIP policies are outlined below. If finalized, these policies would be effective beginning January 1, 2024.

- **Progress to performance-based risk.** CMS proposes to modify the AIP eligibility requirements to allow an ACO to elect to advance to a two-sided model level of the BASIC track's glide path beginning with the third performance year of the five-year agreement period in which the ACO receives AIP.
- **AIP recoupment.** CMS proposes to modify AIP recoupment and recovery policies to forgo immediate collection of AIP from an ACO that terminates its participation agreement early in order to early renew under a new participation agreement. CMS would only recoup AIP from the shared savings of the ACO instead of directly recouping the payments from the ACO.

- **AIP termination.** CMS proposes to modify termination policies to specify that CMS would immediately terminate AIP to an ACO for future quarters if the ACO voluntarily terminates from the MSSP.
- **Spend plan reporting.** CMS proposes to require ACOs to submit AIP spend plan updates and actual spend information to CMS in addition to publicly reporting that information.
- **AIP calculation reconsideration.** CMS proposes to modify AIP requirements to permit ACOs to seek reconsideration review of all quarterly AIP calculations.

Key Takeaway: CMS requests stakeholder input on future MSSP policy developments.
CMS solicits comments on potential future developments to MSSP policies, including the following:

- Incorporation of a track with higher risk and potential reward than the ENHANCED track
- Modification of the amount of the prior savings adjustment through potential changes to the 50% scaling factor used in determining the adjustment
- Considerations for potential modifications to the positive regional adjustment to reduce the possibility of inflating the benchmark
- Potential refinements to the accountable care prospective trend and the three-way blended benchmark update factor over time to further mitigate potential unintended effects
- Policies that would enhance collaboration between ACOs and community-based organizations.

Other Proposals

Medicare Diabetes Prevention Expanded Model

Key Takeaway: CMS proposes modifications to the Medicare Diabetes Prevention Expanded Model (MDPP) to boost supplier enrollment, increase participation by Medicare beneficiaries and simplify the payment structure.
MDPP is an evidence-based behavioral intervention that aims to prevent or delay the onset of type 2 diabetes for eligible Medicare beneficiaries diagnosed with prediabetes. MDPP was established in 2017 as an "additional preventive service" covered by Medicare and not subject to beneficiary cost-sharing, in addition to being available once per lifetime to eligible beneficiaries. MDPP is a non-pharmacological behavioral intervention consisting of no fewer than 22 intensive sessions using a Centers for Disease Control and Prevention (CDC) approved National Diabetes Prevention Program curriculum.

CMS proposes the following modifications to the MDPP:

- Removing the definition for the core maintenance session interval while adding definitions for combination delivery, distance learning and online delivery modalities, among other definitions. The core maintenance session interval represents a performance interval for attendance-based payments in the current payment structure. CMS proposes removing the core maintenance session interval to make the payment structure less confusing.
- Modifying the payment structure by eliminating attendance-based performance payments and instead proposing fee-for-service payments for beneficiary attendance. CMS would also pay for diabetes risk reduction (*i.e.*, weight loss) on a performance basis.
- Extending the flexibilities allowed under the COVID-19 PHE for a period of four years, until December 31, 2027. These flexibilities include remotely obtaining weight measurements and

eliminating the maximum number of virtual services. CMS believes that extending the flexibilities will boost supplier enrollment, with the goal of increasing beneficiary participation and retention due to increased access to the set of MDPP services. Moreover, extending the PHE flexibilities may increase equitable access to diabetes preventive services among rural and at-risk populations.

- Requiring that organizations be fully recognized by the CDC through the Diabetes Prevention Recognition Program rather than allowing for an "interim preliminary recognition" status.

Refunds for Discarded Amounts of Single-Dose or Single-Use Package Drugs

Key Takeaway: CMS proposes quarterly discarded drug refund reports begin in 2024 alongside additional implementation policies.

Section 90004 of the Infrastructure Investment and Jobs Act requires manufacturers to provide a refund to CMS for certain discarded amounts from single-dose container or single-use package drugs. Hospital outpatient departments and ambulatory surgery centers are required to report the JW billing modifier to determine the total number of billing units of the HCPCS code of a refundable drug, with a few exceptions. A JZ billing modifier is used to indicate that no amount of the drug was discarded.

CMS proposes that the initial discarded drug refund report to manufacturers would be issued no later than December 31, 2024, and subsequent reports would be issued quarterly. Annual reports would include lagged claims data from two years prior, which would be used to revise the manufacturer refund amount. When there are multiple manufacturers for a refundable drug, CMS proposes that refunds be apportioned by proportion of billing unit sales.

CMS also proposes that drugs with low volume doses and rarely administered orphan drugs receive increased applicable percentages, which lowers the refund amount owed by manufacturers. CMS proposes that a formal application process for manufacturers seeking increased applicable percentages be established alongside this policy.

Self-Administered Drug Products Request for Information

Key Takeaway: CMS solicits comments regarding policies on the exclusion of coverage for certain drugs under Part B that are usually self-administered by the patient.

CMS seeks comment on coding and payment policies for complex non-chemotherapeutic drugs, to promote coding and payment consistency and patient access to infusion services.

Clinical Laboratory Fee Schedule

Key Takeaway: CMS proposes conforming changes to the Protecting Access to Medicare Act of 2014 (PAMA) data reporting and payment requirements.

CMS proposes to make conforming changes to reflect the most recent changes to the PAMA data reporting requirements and the payment requirements. In December 2021, Congress passed the Protecting Medicare and American Farmers from Sequester Cuts Act that further delayed the data reporting timeline for data collected in Q1 and Q2 2019. Specifically, it established the data collection period as January 1, 2023, through March 31, 2023, for rates that would become effective January 1, 2024. The law also required that Clinical Laboratory Fee Schedule rates not be reduced by more than 0% between 2021 and 2022, and that payment rates in CYs 2023–2025 not drop by more than 15% each year when compared to the preceding year. In this proposed rule, CMS proposes to make the necessary conforming changes to reflect the current requirements.

The agency proposes to update the regulatory definition of both the "data collection period" and the "data reporting period," specifying that for the data reporting period of January 1, 2024, through March 31, 2024, the data collection period is January 1, 2019, through June 30, 2019. CMS also proposes

revisions to indicate that initially, data reporting began January 1, 2017, and is required every three years beginning January 2024.

Appropriate Use Criteria Program

Key Takeaway: CMS proposes to pause the AUC program indefinitely.

PAMA Section 218(b) established the AUC program. Under this program, a practitioner who orders an advanced diagnostic imaging service for a Medicare beneficiary in an applicable setting is required to consult an AUC using a qualified clinical decision support mechanism. The practitioner furnishing the imaging service must report the AUC consultation information on the Medicare claim.

In the CY 2018 rulemaking cycle, CMS established January 1, 2020, as the effective date for the program, with the first year serving as the operations and education testing period. In July 2020, in response to the COVID-19 PHE, CMS extended the testing period an additional year. In the CY 2022 PFS final rule, CMS finalized its policy to delay the payment penalty phase of the AUC program until January 1, 2023, at the earliest.

Last year, CMS announced a further delay to the start of the penalty phase of the program in conjunction with the release of the proposed rule. CMS stated on the AUC program website that the educational and testing program would continue until further notice and that the penalty phase would not begin on January 1, 2023, even if the PHE ended in CY 2022.

In this year's rule, CMS proposes to take more permanent action on the AUC program by indefinitely pausing the program to allow the agency to re-evaluate the program and consider next steps, if any. The primary driver for the decision is CMS's acknowledgment that it has too many operational challenges in implementing the real-time claims-based reporting requirement, referring to these challenges as "insurmountable barriers." Without a clear path to implement the program, CMS acknowledges that continuing the educational and testing period is not the right course of action. As such, CMS proposes to rescind the regulations governing the program. While it proposes to permanently pause the program, CMS still encourages the use of clinical decision support mechanisms where these mechanisms fit within the clinical workflow and meet the needs of the end user.

COVID-19 Vaccine Administration Services

Key Takeaway: CMS proposes an additional payment for in-home COVID-19 vaccine administration.

In June 2021, CMS announced an additional payment for in-home COVID-19 vaccine administration that allows providers and suppliers that administer a COVID-19 vaccine in the home to bill Medicare for an existing COVID-19 vaccine administration CPT code as well as HCPCS code M0201 (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). These policies were established on a preliminary basis to allow for greater access to COVID-19 vaccines during the pandemic. However, in the CY 2023 PFS final rule, CMS extended this payment past the end of the PHE for another year in order to provide time to collect data on utilization and trends associated with its use, to inform the Part B preventive vaccine policy on payments for in-home vaccine administration for CY 2024.

For CY 2024, CMS proposes to maintain the in-home additional payment for COVID-19 vaccine administration under the Part B preventive vaccine benefit and also proposes to extend the additional payment to the administration of the other three preventive vaccines included in the Part B preventive vaccine benefit (pneumococcal, influenza and hepatitis B vaccines) effective January 1, 2024. CMS notes that if this proposal is finalized, the agency would broaden the conditions for payment to reflect preventive vaccines for the other diseases. CMS proposes to limit the additional payment to one payment per home visit, even if multiple vaccines are administered at the same visit. This additional

payment amount would be annually updated using the percentage increase in the MEI and adjusted to reflect geographic cost variations.

Medicare Parts A and B Payment for Dental Services

Key Takeaway: CMS proposes payment for dental services inextricably linked to other covered services used to treat cancer.

Medicare Parts A and B pay for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. In the CY 2023 PFS final rule, CMS established a process for the public to submit additional dental services that may be inextricably linked to other covered services.

For CY 2024, CMS proposes to codify previously finalized payment policies for dental services prior to or during head and neck cancer treatments, whether primary or metastatic. CMS also proposes to permit payment for certain dental services inextricably linked to other covered services used to treat cancer, including chemotherapy, CAR T cell therapy and antiresorptive therapy. CMS does not anticipate a significant increase in overall spending and utilization under the PFS for additional dental services performed prior to and during certain cancer treatments or drug therapies, given the historically low utilization of these therapies. CMS continues to seek comment on additional circumstances where evidence supports dental services as an integral part of the clinical success of covered medical services.

Caregiver Training Services

Key Takeaway: CMS proposes to pay physicians and non-physician practitioners when they train and involve caregivers in carrying out a treatment plan for patients with certain diseases or illnesses.

In CYs 2022 and 2023, CMS received AMA RUC recommendations for new caregiver training codes. CMS has historically taken the position that codes describing services furnished to individuals without the patient's presence are not covered under Medicare. In the CY 2023 PFS final rule, while CMS did not establish payment for the codes, it indicated that there could be circumstances where separate payment for caregiver training services may be appropriate and requested public comment on how patients may benefit from caregiver training.

For CY 2024, CMS proposes to pay practitioners when they train and involve caregivers to support patients with certain diseases or illnesses (*e.g.*, dementia) in carrying out a treatment plan. CMS proposes to pay for these services when furnished by a physician, 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) under an individualized treatment plan or therapy plan of care.

Other Policies

The CY 2024 rule also addresses several other proposals, including the following:

- Provisions related to ambulance providers
- Medicare and Medicaid provider and supplier enrollment
- Additional implementation of the Inflation Reduction Act for biologicals.

In summary, the CY 2024 PFS proposed rule outlines how budget neutrality constraints continue to impact Medicare physician payment. Proposed policies can have significant redistributive impacts on other services and providers, creating a source of tension for those under the fee schedule. Moreover, the lack of an inflationary update means that physicians continue to fall behind other Medicare payment systems. CMS itself notes that the MEI will increase by 4.5%, while the proposed CF will decline by more

than 3.3%. Stakeholders will likely again turn to Congress to try to mitigate overall physician payment cuts; however, any action by lawmakers on these issues is unlikely to be addressed until the end of the year, and the appetite to continuously patch physician payments remains unclear.

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