Policy Update

CMS Releases CY 2024 Physician Fee Schedule Final Rule

On November 2, 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-F] Final Rule, which includes policies related to Medicare physician payment and the Quality Payment Program (QPP). Physicians and other clinicians once again face large cuts—more than **3.37%** for CY 2024, a slightly larger cut than was outlined in the proposed rule. The finalized conversion factor (CF) update is primarily based on three factors: a statutory 0% update scheduled for the PFS in CY 2024, a negative 2.18% budget neutrality adjustment due to final PFS policies, and a funding patch passed by Congress at the end of CY 2022 through the Consolidated Appropriations Act, 2023 (CAA, 2023), which partially mitigated a cut to the CY 2023 CF and offset part of the reduction to the CY 2024 CF.

While Congress has provided temporary partial fixes to physician payment in the last several years, the relief from the CAA, 2023, does not offset all the cuts in this rule. Lawmakers are considering legislative options, but it remains unclear whether relief will be provided before the start of 2024. Beyond the cut to the CF, CMS finalized significant policies related to telehealth services, updates to the Medicare Shared Savings Program (MSSP), initiatives promoting coverage and payment for additional services, and other changes to further develop physician quality initiatives.

Key takeaways from the CY 2024 PFS Final Rule:

- *CF Reduction:* CMS finalized a 2024 CF of $32.7442, representing a 3.37% reduction from the 2023 physician CF of $33.8872, and a 2024 anesthesia CF of $20.4349, representing a 3.27% reduction from the 2023 anesthesia CF of $21.1249.
- *Add-on Code for Complexity:* The final rule implements a new add-on code for complexity, G2211, which was previously finalized but delayed by Congress until 2024.
- *Telehealth:* While no new codes were permanently added to the Medicare Telehealth Services List, CMS finalized a new process for adding, removing or otherwise changing codes on the list and created differential payment based on the place of service.
- Merit-Based Incentive Payment System *(MIPS):* MCMS maintained the MIPS performance threshold at 75 points, backing away from its initial proposal to make the program more challenging in 2024 by raising the threshold to 82 points.
- *Appropriate Use Criteria (AUC) Program:* The final rule permanently sunsets the AUC program
- *MSSP:* The final rule implements changes to the MSSP, including to the financial benchmarking methodology and assignment methodology.
- *Advancing health equity:* CMS finalized new codes and payment methods for social determinants of health risk assessments, community health integration, principal illness navigation and caregiver training services.

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

- The final 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 Policies

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: The CY 2024 CF is $32.7442, a reduction of more than 3.37% from CY 2023.

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	**32.7442**	**-3.37**

The 2024 physician CF is **$32.7442**. This represents a decrease of approximately **3.37%** from the 2023 CF of $33.8872. The 2024 anesthesia CF is **$20.4349**, which represents a decrease of approximately **3.27%** from the 2023 anesthesia CF of $21.1249.

The update is primarily based on three factors: a statutory 0% update scheduled for the PFS in CY 2024[1], a negative 2.18% budget neutrality adjustment, and a funding patch passed by Congress at the end of CY 2022 through the CAA, 2023. That 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 for 2023	Net Effect with CAA for 2024
Medicare Physician CF Reduction	-4.47%	-2.08% (added 2.5%)	-3.37% (added 1.25%)
PAYGO Sequestration	-4%	0%	0%
Total Cuts*	-8.47%	-2.08%	-3.37%

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

[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.

back in effect.

According to CMS, approximately 90% of the negative 2.18% 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 discussed later in this summary.

These payment reductions come at a time when physician practices, hospitals that employ physicians, and other stakeholders face rising costs due to inflation, staffing shortages and significant challenges posed by other regulatory burdens (*e.g.*, prior authorization, interoperability requirements and participation in Medicare quality programs such as MIPS). In light of these burdens, the provider community likely will press Congress for relief, although it is unclear whether lawmakers are willing to fully offset the 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 (MEI). However, the cost of this legislation may be prohibitive to finding sufficient support to pass the bill. Accordingly, Congress may introduce or consider other reforms later this year.

Specialty Impact

Key Takeaway: Impact by specialty ranges from -4% to +3%.
Actual payment rates are affected by a range of finalized policy changes related to physician work, PE and malpractice RVUs. CMS summarizes the aggregate impact of these changes in Table 118 in the final rule. While impact on individual practices would vary based on service mix, the table provides insight into the overall impact of the rule's policies 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 118.

Most of the differences in specialty impact result from finalized changes to individual procedures. The finalized implementation of the separate payment for the new add-on code for complexity, third year of the clinical labor pricing update and finalized 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 audiology.

Impact of finalized 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	$5,538	2%	2%	0%	3%
Endocrinology	$509	1%	1%	0%	3%
Internal Medicine	$9,683	0%	1%	0%	1%
Nuclear Medicine	$51	-1%	-2%	0%	-3%
Radiology	$4,536	-1%	-2%	0%	-3%
Vascular Surgery	$1,011	-1%	-3%	0%	-3%
Interventional Radiology	$458	-1%	-3%	0%	-4%

Note: Combined impact may not equal the sum of work, PE and malpractice as a result of rounding.
Source: Table 1184 CY 2024 Final PFS, display copy.

Additional detail showing the facility/non-facility payment impact by specialty from the proposed changes can be found in Table 119.

Implementation of New Add-On Code for Complexity

Key Takeaway: CMS finalized its proposal to implement the new add-on code and did not change proposed utilization estimates.

CMS will implement a new add-on code for complex patients, G2211, that can be reported with office and outpatient (O/O) evaluation and management (E/M) codes.[2] A primary policy goal of G2211 is to reimburse certain physicians, such as family medicine physicians, more appropriately for the care they provide to highly complex patients. In the proposed rule, CMS assumed that G2211 would be reported with 38% of all O/O E/M visit claims initially. CMS estimated that when fully adopted after several years, G2211 would be billed with 54% of all O/O E/M visit claims. The proposed utilization assumption led to a significant projected increase in spending, yielding an approximate 2% reduction to the proposed CF to maintain budget neutrality. CMS also proposed to prohibit G2211 from being 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 as a procedure or other service.

Although CMS acknowledged public comments that urged the agency to revise the utilization assumptions, CMS believes that the proposed utilization assumptions are accurate and finalized them as proposed. In response to comments that CMS should reduce its utilization assumptions in line with the initial utilization of the care management codes for transitional care management and chronic care management codes, CMS stated that it does not believe that the utilization of these codes is an appropriate proxy for the utilization of this add-on code. CMS also believes its additional clarifications about when it is appropriate to bill the code (discussed below) will give practitioners increased confidence to bill the code appropriately.

With respect to commenters' concerns that it is unclear when it is appropriate to bill the code, CMS clarified in the final rule that this code is meant to be used for visits associated with longitudinal, non-

[2] 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.

procedural care where the clinician has an ongoing relationship with a patient. CMS believes that for these services, the intensity of the professional work when dealing with a complex patient is not appropriately captured within the current valuation of O/O E/M services and that the add-on code is necessary to ensure that these services are valued accurately. CMS further stated that this code should be used when furnishing O/O E/M visits 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. Thus, the relationship between the patient and the practitioner is the determining factor for when the add-on code should be billed. CMS believes that there is previously unrecognized but important cognitive effort in utilizing the longitudinal relationship itself in the diagnosis and treatment plan and weighing the factors that affect a longitudinal doctor-patient relationship. This policy, according to CMS, will help improve trust and improve outcomes over time as physicians care for patients with a serious illness.

CMS also responded to comments on the payment modifier -25 and finalized the proposal to not make payment for G2211 when the underlying O/O E/M visit has been reported with modifier -25.

In the proposed rule, CMS posed a series of questions about the current process for properly valuing codes under the PFS, including through the Current Procedural Terminology (CPT)®[3] and RUC processes. In the final rule, CMS outlined the feedback it received on each of its questions and included brief responses. CMS stated that it will consider all the public comments on steps it could take to improve the accuracy of valuing services and how the agency might evaluate E/M services comprehensively, more regularly and with greater specificity in future rulemaking.

Practice Expense

Key Takeaway: CMS strategies for updating 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 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

[3] CPT® is a registered trademark of the American Medical Association

societies involved in the previous PPIS data collection effort, and to 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 encouraged 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, including feedback on five specific questions. These questions are detailed in our CY 2024 proposed rule summary.

In the CY 2024 final rule, CMS summarized responses from commenters. Most commenters stated that CMS should defer significant changes to the PE methodology until the AMA PPIS results become available. However, some commenters stated that dependence on the PPIS or survey data in general may continue to jeopardize independent practice and discourage fair competition among suppliers and providers of services under the PFS. Other commenters stated that, regardless of whether one supports updating and using updated PPIS data, the duration between updates and the expense of fielding a survey may promote further market consolidation. Finally, a comment co-signed by a broad and varied set of interested parties requested a separate request for information, outside of the annual PFS rulemaking cycle, that addresses topics related to machine learning, artificial intelligence and software, which may require more significant changes than would be practical to address in a given calendar year.

Clinical Labor Pricing Update

Key Takeaway: CMS finalized an increase to one clinical labor type in response to stakeholder feedback. All other clinical labor pricing policies remain unchanged from the proposed rule. 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 5, CY 2024 Final 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. However, during the comment period, several commenters stated that CMS created a rank order anomaly in the pricing of the cytotechnologist (L045A) clinical labor type when it increased the clinical labor rates for the vascular interventional technologist (L041A), mammography technologist (L043A) and CT technologist (L046A) in CY 2023. In response to additional data provided by commenters, CMS finalized an update in the clinical labor pricing of the L045A clinical labor type from $0.76 to $0.85. Aside from this cytotechnologist

(L045A) clinical labor type, all other clinical labor pricing remains unchanged from the proposed rule.

Rebasing and Revising the Medicare Economic Index

Key Takeaway: CMS again delayed implementation of the 2017-based MEI.
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 in the process of doing so, which means the MEI continues to reflect 2006 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.

For CY 2024, CMS finalized its policy, as proposed, to continue to delay implementation of the 2017-based MEI. Many commenters supported this policy and further urged CMS to pause consideration of other sources for the MEI until the AMA's efforts to collect practice cost data from physician practices have concluded.

Split (or Shared) Services

Key Takeaway: CMS established the definition of "substantive portion" of a split or shared service in 2024 to mean more than half of the total time spent by the physician and the non-physician practitioner (NPP) performing the split (or shared) visit, or a substantive part of the medical decision making (MDM)—aligning with CPT® guidelines.

In the CY 2022 PFS final rule, CMS finalized a policy for determining whether a physician or an NPP 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 NPPs 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, in 2023 and subsequent years, only time would be used for the purposes of determining the substantive portion of a split/shared service.

Many physician specialty societies strongly opposed 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 allow the determination to be made based on time or MDM. In the CY 2023 rule, CMS delayed implementation of the full transition to time only until 2024. For 2023, 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 the CY 2024 proposed rule, CMS proposed to delay the transition to time only and continue its current

policy in 2024. However, based on feedback received from commenters, who urged CMS to align the policy with CPT guidance for reporting split (or shared) visits using MDM, CMS ultimately decided to create a seemingly more permanent policy. CMS adopted the CPT guidelines for CY 2024, meaning that the definition of "substantive portion" will be more than half of the total time spent by the physician and NPP performing the split/shared visit, or a substantive part of the MDM as defined by CPT. CMS noted that it finalized this policy for CY 2024 partly to avoid the administrative burden, as described by commenters, that would otherwise be present for practices that spend time and resources preparing for potential policy changes that are delayed year after year. If warranted, CMS will address any subsequent policy change through notice-and-comment rulemaking.

Potentially Misvalued Codes

Key Takeaway: CMS finalized its proposal to nominate 19 therapy codes as potentially misvalued.

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 finalized its proposal to consider the 19 therapy codes, which CMS last reviewed in the CY 2018 PFS final rule, as potentially misvalued. CMS stated that it believes the valuation of these services would benefit from additional review through the AMA RUC Health Care Professionals Advisory Committee valuation process. CMS reviewed the clinical labor time entries for these codes and noted that it does not believe that a payment reduction should have been applied to the clinical labor time entries since the payment valuation reduction would be duplicative of the Multiple Procedure Payment Reduction applied during claims processing. No commenters opposed this proposal.

Based on reviewer comments, CMS also finalized the nominated CPT codes 59200, 36514, 36516 and 36522 as potentially misvalued.

Codes nominated as potentially misvalued that CMS finalized as potentially misvalued:

Code	Descriptor
59200	Insertion cervical dilator (*e.g.*, laminaria, prostaglandin)
36514	Therapeutic apheresis; for plasma pheresis
36516	Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion
36522	Photopheresis, extracorporeal

CMS did not finalize the nominated CPT codes 27279, 99221–99223, 42205, 93655, 93657, 94762, 95800, 93000, 0596T and 0597T as potentially misvalued.

Services Advancing Health Equity and Caregiver Training

Key Takeaway: CMS finalized new codes and payment methods for social determinants of health (SDOH) risk assessments, community health integration (CHI) services, principal illness navigation (PIN) services and caregiver training services.

CMS finalized an additional payment for the SDOH risk assessment service as an optional, additional element of the annual wellness visit with no beneficiary cost sharing. CMS did not mandate a specific list of approved assessments but encouraged clinicians to explore the many widely adopted and validated

tools available, including the CMS Accountable Health Communities tool; the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences tool; and instruments identified for the Medicare Advantage Special Needs Population Health Risk Assessment.

CMS finalized the adoption of a new standalone G code for administering an SDOH risk assessment as part of a comprehensive social history when medically reasonable and necessary in relation to an E/M visit (beneficiary cost sharing may apply when the assessment is not conducted as part of the annual wellness visit). This code will also receive permanent status on the Medicare Telehealth List beginning in CY 2024. The aim is to allow behavioral health practitioners to furnish the SDOH risk assessment in conjunction with the behavioral health office visits they use to diagnose and treat mental illness and substance use disorders.

CMS also finalized the creation of two new G codes to pay for CHI services. CHI services focus on addressing the particular SDOH needs that interfere with, or present a barrier to, diagnosis or treatment of the patient's problem(s) addressed in the CHI initiating visit. CHI services can be performed by certified or trained auxiliary personnel, which may include community health workers or others who are external to, and under contract with, the practitioner or the practitioner's practice, such as through a community-based organization. Understanding the significant and variable time potentially required, CMS did not establish a frequency limitation for the relevant HCPCS code; however, CHI services may not be billed while the patient is under a home health plan of care.

Similarly, CMS finalized new coding for PIN services, which can be furnished following an initiating E/M visit addressing a serious high-risk condition/illness/disease expected to last longer than three months, such as cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/AIDS, severe mental illness and substance use disorder.

PIN services can be provided by trained patient navigators or certified peer specialists, and can be provided more than once per practitioner per month. CMS will monitor utilization of the codes going forward to ascertain the time spent per month per PIN service, and requires that a new initiating visit be conducted once per year. Written or verbal patient consent will be required in advance of providing PIN and CHI services, which was not initially proposed.

CMS also finalized new coding and payment for caregiver training services, so that practitioners are appropriately paid for engaging with caregivers to facilitate the patient's functional performance in the home or community. CMS will use both the Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act definition and the CMS Outreach and Education definition (*i.e.*, a family member, friend or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition) of caregiver.

Behavioral Health

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

CMS finalized its process to implement several provisions of the CAA, 2023, with the intent of encouraging and expanding access to behavioral health services. The final rule provides Medicare Part B coverage and payment for the services of marriage and family therapists (MFTs) and mental health counselors (MHCs). CMS finalized its proposal to allow addiction counselors that meet all the applicable requirements to be an MHC to enroll in Medicare as MHCs. The final rule also establishes, as required by the CAA, 2023, new HCPCS codes under the PFS for psychotherapy for crisis services, and allows 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 finalized the proposal to

apply an adjustment to the work RVUs for psychotherapy codes over a four-year transition.

CMS also provided commentary on the responses it received to the proposed rule's request for feedback on ways to expand access to behavioral health services and information on digital therapies, including digital cognitive behavioral therapy. Notably, the agency did not agree with the regulatory approach proposed by stakeholders to cover digital therapeutics through existing mechanisms, such as incident-to a physician's service or as durable medical equipment.

Telehealth and Other Remote Services

CMS finalized many of the policies in the proposed rule with minimal changes. The agency will move forward with the change in the categorization of the codes on the Medicare Telehealth Services List, as well as the updated stepwise process for reviewing requests for recategorization or addition of codes. Notably, the agency did not approve any requests to add services to the Medicare Telehealth Services List on a permanent basis. The agency also finalized the change in facility rates for certain place of service codes. CMS discussed its limited ability to provide coverage and payment for certain telehealth services beyond December 31, 2024, due to the expiration of the extension of certain Medicare telehealth flexibilities related to the COVID-19 PHE via the CAA, 2023. 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). If the expiration of these flexibilities is not addressed early in 2024, this limitation may hinder the agency's ability to contemplate changes beyond the end of 2024.

Updates to the Telehealth Services List

Key Takeaway: CMS did not permanently add any services to the Medicare Telehealth Services List.

The Medicare Telehealth Services List contains the telehealth service codes for which Medicare physicians can bill. CMS received requests to permanently add more than 30 codes to the list. CMS did not grant any of these requests, although most codes will remain on the list temporarily. CMS cited a variety of reasons for these decisions, depending on the specific category and request, but some themes emerged. CMS noted that many requestors submitted data that focused on the experience during the pandemic. The agency indicated that because the government is no longer operating under a PHE, data should reflect that. CMS also discussed the temporary nature of the extensions provided for under the CAA, 2023, specifically those related to caring for patients in the home. The agency does not believe it can move codes to a permanent status if they are dependent on temporary policies.

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

Under current policy, Categories 1 and 2 of the Medicare Telehealth Services List 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 acknowledged 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 finalized its proposal to eliminate the use of Categories 1–3 and move to a "permanent" and "provisional" approach.

CMS finalized the following steps for adding, removing or changing the status of services on the

[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 have needed to meet the Category 1 or 2 criteria to be added to the list on a permanent basis.

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 (*i.e.*, 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.

As of January 1, 2024, CMS will 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 will be placed on the "provisional" list. There is no specified timeframe to remove "provisional" codes from the list. Under the agency's new approach, provisional status will be assigned to codes that satisfy the threshold steps (steps 1, 2 and 3 above). CMS will not assign provisional status if it is improbable that the code would ever achieve permanent status. CMS will revisit provisional status through the regular annual submissions and rulemaking processes when a submission provides new evidence, when the agency's claims monitoring shows anomalous activity or when indicated by patient safety considerations. A full list of codes, including the provisional and permanent designations and audio-only, are included in Table 11 of the final rule.

The clarity provided in this new approach has garnered mostly positive feedback from stakeholders. Stakeholders should note the agency's lengthy discussion of step 5 mentioned above, as CMS noted a lack of data and supporting evidence for many of the requests for permanency. The agency also made clear that it is bound by the CAA, 2023, timeline and cannot make assumptions about the temporary Medicare telehealth flexibilities beyond the current expiration date of December 31, 2024.

Telehealth Reimbursement

Key Takeaway: CMS finalized permanent facility rates for certain place of service (POS) codes. 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 rate, which applies when the service is furnished in an office or other setting. The POS is used to determine whether a service is paid using the facility or non-facility rate. 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.)

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

CMS expanded on its position that this policy reflects the trends of telehealth data over the past several years. The agency reiterated 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. CMS also anticipates that the in-person requirement for mental health services provided via telehealth will become effective in CY 2025 (the waiving of this requirement is currently slated to expire December 31, 2024), which will result in a continued mix of in-office and telehealth. The agency believes that the PEs are more accurately reflected by the non-facility rate. Notably, CMS clarified that any service with POS 10 will be paid at the non-facility rate.

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.

While the final rule provides some clarity for stakeholders on the application of the facility and non-facility rates for certain POS codes, stakeholder may want to monitor the impact of these changes on disruptions to care and access to telehealth services, as well as providers' and practices' approach to in-person and virtual care.

Alignment of CAA, 2023, Extension of Medicare Telehealth Flexibilities

In the final rule, CMS aligned PFS payment policies with the extension of Medicare telehealth flexibilities as provided through the CAA, 2023. This effectively means 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 same list as finalized in the CY 2023 final

rule)
- Covering 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 will be added permanently beginning January 1, 2024.

CMS also finalized the continuation of other flexibilities through December 31, 2024, and will reassess in subsequent rulemaking. These flexibilities include the following:

- **Removal of frequency limitations.** CMS will continue its suspension of frequency limitations for certain subsequent inpatient visits, subsequent nursing facility visits and critical care consultations furnished via Medicare telehealth.
- **Direct supervision.** CMS will 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 will 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 will 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.

These changes continue to support utilization of telehealth for Medicare providers and beneficiaries in a post-PHE regulatory environment. However, CMS made clear in the final rule that many of these will end if the current Medicare telehealth flexibilities expire on December 31, 2024 (as currently slated through the CAA, 2023). This uncertainty could prove difficult for patients and providers, especially approaching the end of 2024.

Remote Monitoring Policies

Key Takeaway: CMS clarified remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) 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 they 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 their use. While utilization for the RPM codes again increased, CMS did not propose any policy changes specific to the RPM and RTM codes for CY 2024.

CMS noted that it has received many questions regarding billing scenarios and the appropriate reporting of codes. To broadly share clarifications with stakeholders, and in response to comments submitted following the proposed rule, CMS discussed the following issues in the final rule:

- CMS confirmed the requirement that RPM services only be furnished to established (as opposed to new) patients now that the PHE has ended.
- CMS acknowledged that while it has remained silent on this topic, it believes that RTM should only be furnished to patients after a treatment plan is established, which would occur following "an initial interaction with the patient."
- Now that the COVID-19 PHE is concluded, the 16-day data collection requirement (as opposed to the two-day data collection requirement) is reinstated, although it does *not* apply to the RPM or RTM treatment management codes as erroneously stated in the proposed rule.

- CMS confirmed that RPM or RTM may be separately reimbursable during the global period where the billing provider is not the provider that is receiving the payment for the global procedure.

In response to feedback from stakeholders, CMS finalized its policy to pay for RPM and RTM services furnished in FQHCs and RHCs. CMS will 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 policy is consistent with recent FQHC and RHC policies issued by CMS to improve care management in these settings. To account for this new policy, CMS adjusted the reimbursement rate for G0511 by taking a weighted average utilization of all services that could be reported under this HCPCS code.

The final rule also addresses RTM services furnished by physical and occupational therapists in private practices. Per the policy, these services may be furnished under general rather than direct supervision of therapy assistants.

As part of a broader request for information on digital therapies in the proposed rule, CMS sought input from stakeholders to better understand the current opportunities and challenges related to existing coverage and payment policies for RPM and RTM. As expected, CMS did not make any policy changes in the final rule in response to the feedback, but it will consider this information for future guidance, rulemaking and education.

Provider Home Address

Key Takeaway: CMS extended flexibility through December 31, 2024.

During the PHE, CMS allowed healthcare providers to provide telehealth services from their homes, without reporting their home addresses on their Medicare enrollment, while continuing to bill from their currently enrolled location. This policy provided efficiency and protected the privacy and safety of physicians. Originally, this flexibility was to expire on January 1, 2024.

CMS noted that it received feedback from many stakeholders on this issue and decided to keep this flexibility in place through December 31, 2024. The agency seeks additional feedback from stakeholders to inform future rulemaking. CMS specifically requests clear examples of how the enrollment process shows "material privacy risks," and wishes to better understand the considerations involved in including a practitioner's home address as an enrolled practice location when that address is the distant site location where the practitioner furnishes Medicare telehealth services.

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 maintained the program threshold of 75 points to avoid a MIPS penalty.

To avoid a negative adjustment and be eligible for a positive payment adjustment, a provider's MIPS total score must reach a performance threshold. 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.

CMS proposed to increase the MIPS performance threshold of 75 points to 82 points for the 2024 performance period. Under the proposed rule, CMS considered a "prior period" to establish the performance threshold, defined as three performance periods, rather than the mean score from a single performance period. CMS estimated that if it increased the threshold to 82 points, almost half of participants would likely see a MIPS penalty.

Based on many comments from stakeholders that opposed the potential impact on clinician reimbursement, CMS maintained the 75-point threshold for MIPS for 2024. CMS stated that it will not use the "performance period" approach for this year but will continue to set the threshold by looking at a single year for the 2024 performance period. CMS notes that it could consider this approach again in future rulemaking, however. Based on this change, CMS now estimates that approximately 22% of clinicians will see a negative MIPS adjustment.

CMS did not directly address new policies for participants who are already high performers, although the agency noted stakeholder feedback on this topic. CMS is concerned that these participants may repeatedly choose the same measures and activities on which they are confident they will perform well. To address this issue in future rulemaking, CMS is considering modifying scoring policies to encourage these clinicians 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 finalized proposals 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 Weight
Quality	30%	30%
Cost	30%	30%
Promoting Interoperability	25%	25%
Improvement Activities	15%	15%

Quality Category

CMS finalized changes that will result in a total of 198 quality measures in its quality inventory (not including Qualified Clinical Data Registry (QCDR) measures). Specific measures are outlined in more detail in the QPP fact sheet and include the addition of 11 measures (see Appendix B), removal of 11 quality measures (see Appendix D), 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 F) and substantive changes to 59 existing quality measures. Lastly, the agency will require the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey in Spanish.

In another win for provider stakeholders, CMS also maintained the data completeness criteria threshold of at least 75% through the CY 2026 performance period/2028 MIPS payment year, without plans to raise the threshold to 80% for the CY 2027 performance period/2029 MIPS payment year.

Cost Category

CMS will add five new episode-based measures to the cost performance category beginning with the CY 2024 performance period. Each measure will have a case minimum of 20 episodes for CMS to correctly score the measure. The measures are related to depression, emergency medicine, heart failure, low back pain, and psychoses and related conditions. For CY 2024, CMS will also remove the Simple Pneumonia with Hospitalization episode-based cost measure.

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 2020–2024 MIPS payment years, CMS will start with a one percentage point improvement score beginning with the 2025 MIPS payment year. The agency finalized that improvement scoring will occur at the category level without using statistical significance, similar to how it scores improvement in other categories.

Improvement Activities

CMS will add five, modify one and remove three improvement activities from the improvement activities inventory (see Appendix H). The agency did move forward with an MVP-specific improvement activity titled Practice-Wide Quality Improvement in MIPS Value Pathways that would incentivize movement out of traditional MIPS by allowing clinicians to receive full credit in this performance category when they report the chosen MVP and attest to having completed the necessary elements of the MVP improvement activity.

In total, there will be 106 improvement activities in the MIPS inventory for the 2024 performance period.

Promoting Interoperability

CMS will lengthen the performance period for this category from 90 to 180 days, and adopted the following changes:

- Modification of one of the exclusions for the Query of Prescription Drug Monitoring Program measure
- A technical update to the ePrescribing measure
- Modification of 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.

In the past, CMS allowed certain participants to not be scored in the promoting interoperability category and re-weighted the other MIPS categories as appropriate. CMS will not 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. It will, however, continue to automatically reweight this performance category for clinical social workers; ASC-based, hospital-based and non-patient-facing clinicians and groups; and clinicians in a small practice.

Data Submission

To submit MIPS data, clinicians currently can use health information technology (IT) vendors, QCDRs or qualified registries. Because of concerns over inaccurate data submission, CMS will eliminate the health IT vendor category beginning with the CY 2025 performance period. Health IT vendors will 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 will no longer be able to 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 will incorporate Medicare Advantage encounter data for a more accurate representation of procedure volumes.

QPP: MIPS Value Pathways

Key Takeaway: CMS finalized 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.

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

MVP participants will 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 a sufficient 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 2025 and how fast the transition away from traditional MIPS will occur.

Advanced APM Track

[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.

Key Takeaway: CMS codified certain sections of the CAA, 2023, that extended the Advanced APM bonus and froze Qualifying Participant (QP) thresholds. However, without further congressional action, the bonuses will expire and the QP thresholds will increase in performance year 2024. CMS decided not to finalize proposals to make all QP determinations at the individual level rather than at the entity level.

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 the CY 2023 rule, CMS sought feedback on whether administrative action would be necessary to continue to incentivize Advanced APM participation.

QP Determinations: 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 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 fewer services that lead to attribution in order to meet the QP threshold. Thus, in the proposed rule, CMS reconsidered the policy of making most QP determinations at the APM entity level and instead, beginning with the QP performance period for CY 2024, making all QP determinations at the individual level. However, **CMS ultimately decided not to finalize the proposal to end the use of APM entity-level QP determinations and make all QP determinations at the individual eligible clinician level.** CMS will therefore continue making QP determinations at the APM entity 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. 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

CMS finalized proposals 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.

CMS also updated 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 updated 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 finalized proposals to refine the Advance Investment Payments (AIP) qualifying ACOs can receive to help with the significant costs associated with starting an ACO.

CMS acknowledged 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 policies 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 finalized proposals are outlined below.

Key Takeaway: CMS removed the option for a governance exception and clarified the agency's method for determining an ACO's level of experience with performance-based risk.
CMS finalized proposed 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. In the CY 2024 final rule, CMS removed 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 necessary capital and infrastructure for ACO formation and administration.

- **Determining ACO experience with performance-based risk.** CMS codified an operational approach in determining an ACO's level of experience with performance-based risk 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 finalized several updates to the quality performance standard.
CMS revised the MSSP quality reporting and quality performance requirements. Key policies include the following:

- **Medicare CQMs.** For performance year 2024 and subsequent performance years, CMS will establish the Medicare CQMs for Accountable Care Organizations Participating in the Medicare Shared Savings Program as a new collection type for MSSP ACOs under the APM Performance Pathway. CMS will provide all ACOs with a list of beneficiaries eligible for Medicare CQMs each quarter throughout the performance year. Standards for data completeness, benchmarking and

scoring ACOs for the Medicare CQM collection type will align with the MIPS benchmarking and scoring policies. CMS also finalized policies to apply the MSSP health equity adjustment to an ACO's MIPS quality performance category score when calculating shared savings payments to advance health equity and to better support ACOs that deliver high-quality care while also serving a high proportion of underserved individuals. **ACOs will continue to have the option to report quality data using the CMS web interface measures, eCQMs and/or MIPS CQMs collection types in performance year 2024,** in addition to the new option to report quality data using Medicare CQMs. In performance year 2025 and subsequent performance years, ACOs will have the option to report quality data using the eCQMs, MIPS CQMs and/or Medicare CQMs collection types.

- **Health equity adjustment underserved multiplier.** CMS finalized policies to recognize beneficiaries with partial year (not just full year) Medicare Part D low-income subsidy enrollment or dual eligibility for Medicare and Medicaid in calculations of the health equity adjustment underserved multiplier to encourage ACOs to serve this population. CMS also finalized policies to remove beneficiaries who do not have a numeric national percentile Area Deprivation Index rank from the health equity adjustment calculation for performance year 2023 and subsequent performance years.

- **Use of historical data for MIPS quality performance category score.** CMS finalized proposals to use historical data to establish the 40th percentile MIPS quality performance category score used for the quality performance standard. CMS will 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 will be based on averaging the 40th percentile MIPS quality performance category scores from performance years 2020 through 2022. This approach allows CMS to provide MSSP ACOs with the quality performance standard they must meet to share in savings at the maximum sharing rate prior to the start of the performance year.

- **Certified electronic health record technology (CEHRT) requirements.** To align MSSP CEHRT requirements with MIPS, CMS finalized its proposed policies but will delay implementation by one year to give ACOs time to work with their participants to meet the new requirements. For performance years beginning on or after **January 1, 2025** (unless otherwise excluded), an ACO participant; ACO provider/supplier; and ACO professional that is a MIPS eligible clinician, QP or Partial QP, regardless of track, will be required to report the MIPS Promoting Interoperability performance category measures and requirements to MIPS and earn a score for the MIPS Promoting Interoperability performance category at the individual, group, virtual group or APM entity level. To reduce burden and further align with MIPS, CMS finalized certain exclusions from the new reporting requirements and provided options to report the MIPS Promoting Interoperability performance category at the individual, group, virtual group or APM entity level. CMS also decided to delay implementation of the proposed ACO public reporting requirement related to CEHRT use by one year.

- **Case minimum requirement.** CMS finalized proposals to replace references to meeting the case minimum requirement with the requirement that the ACO receive a MIPS quality performance category score to meet the quality performance standard.

Key Takeaway: CMS finalized key changes to the assignment methodology. For the performance year beginning on January 1, 2025, and subsequent years, CMS finalized notable revisions to the MSSP

assignment methodology, including the following:

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

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

- **New definitions.** CMS added 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 applies 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 change aims to better account for beneficiaries who may receive primary care from NPPs (*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.

CMS believes these changes will improve equity and access to ACOs while promoting the US Department of Health and Human Services Initiative to Strengthen Primary Care by better recognizing the types of clinicians who deliver primary care. CMS estimates that the new assignment methodology will grow assignable beneficiaries by more than 760,000.

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

- **Regional service area risk score growth.** CMS will 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. This cap will be applied regardless of whether the ACO's prospective risk score growth was capped.

- **Benchmark risk adjustment.** CMS will 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). The methodology will operate on the same three-year phase-in as the revised Medicare Advantage risk adjustment model: for performance year 2024, CMS will use 67% of the 2020 CMS-HCC risk adjustment model (version 24) and 33% of the 2024 model (version 28).

- **Negative regional adjustment.** CMS finalized its proposal to eliminate overall negative regional adjustments. CMS believes this will support participation by ACOs serving medically complex and high-cost populations.

Key Takeaway: CMS refined the AIP policies.
In the CY 2023 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 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. CMS finalized key refinements to the AIP policies as outlined below, effective beginning January 1, 2024:

- **Progress to performance-based risk.** CMS will 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.** An ACO receiving AIPs will be permitted to early renew its participation agreement after its second performance year without automatically triggering full recoupment of AIPs at that time.
- **AIP termination.** CMS will immediately terminate AIPs to an ACO for future quarters if the ACO voluntarily terminates from the MSSP.
- **Spend plan reporting.** CMS will require ACOs to submit AIP spend plan updates and actual spend information to CMS in addition to publicly reporting that information.
- **AIP calculation reconsideration.** ACOs that receive AIPs may seek reconsideration review of quarterly AIP calculations.

Key Takeaway: CMS will consider stakeholder input on future MSSP policy developments.
CMS acknowledged receiving stakeholder feedback on future areas of MSSP policy development, including the following:

- Potential incorporation of a track with higher risk and potential reward than the ENHANCED track
- Modifications to the prior savings adjustment
- 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
- Ways to enhance collaboration between ACOs and community-based organizations
- Ways to encourage specialist participation.

Other Proposals

Medicare Diabetes Prevention Expanded Model

Key Takeaway: CMS modified 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 finalized the following modifications to the MDPP:

- CMS removed the definition for the core maintenance session interval and added 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 removed the core maintenance session interval to make the payment structure less confusing.
- CMS modified the payment structure by eliminating attendance-based performance payments and instead providing fee-for-service payments for beneficiary attendance. CMS will also pay for diabetes risk reduction (*i.e.*, weight loss) on a performance basis.
- CMS extended 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.
- CMS now requires organizations to be fully recognized by the CDC through the Diabetes Prevention Recognition Program rather than allowing for an "interim preliminary recognition" status.

CMS stopped short of allowing virtual-only providers to enroll in Medicare as MDPP suppliers.

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

Key Takeaway: CMS finalized its proposal that 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 finalized that the initial discarded drug refund report to manufacturers will be issued no later than December 31, 2024. Annual reports will include data from the four quarters of the previous year and four quarters from two years prior. CMS finalized, as proposed, that refunds be apportioned by proportion of billing unit sales when there are multiple manufacturers for a refundable drug.

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

Provider and Supplier Enrollment

Key takeaway: CMS finalized additional reasons for revocation of a provider or supplier's Medicare enrollment, but did not finalize its proposal for revocation or denial based on a misdemeanor conviction. CMS also finalized a new "stay of enrollment" status but clarified that retroactive payment of claims will be permissible.

CMS finalized several additions to the regulations governing when a Medicare provider or supplier's enrollment may be revoked or denied. CMS finalized the following as proposed:

- A broader non-compliance definition
- An expanded list of regulations that, if violated, would be grounds for revocation of the enrollment of an IDTF, DMEPOS supplier, OTP, HIT supplier or MDPP
- Changes in the scope of CMS's ability to revoke enrollment if a provider or supplier has an existing debt that CMS has referred to the US Department of the Treasury.

CMS also finalized, as proposed, that it may revoke enrollment if a provider or supplier, or any owner, managing employee or organization, officer or director thereof, has had a civil judgment under the False Claims Act imposed against them within the previous 10 years. CMS did not finalize its proposal to allow for revocation or denial of a Medicare provider or supplier's enrollment based on a misdemeanor conviction.

CMS finalized its proposal to create a new "stay of enrollment" status for a provider or supplier not in compliance with enrollment requirements. In its final policy, CMS clarified that retroactive payment of claims is permissible if a provider or supplier comes into compliance with enrollment requirements.

CMS also finalized its proposals around requirements that providers and suppliers report changes in their practice location.

Clinical Laboratory Fee Schedule

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

CMS proposed to make conforming changes to reflect the most recent changes to the PAMA data reporting requirements and 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 the CY 2024 final rule, CMS concurred with stakeholders and agreed to make the necessary conforming changes to reflect the current requirements.

Appropriate Use Criteria Program

Key Takeaway: CMS paused 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.

In 2023, 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 the CY 2024 rule, CMS finalized its proposal to indefinitely pause the program to allow the agency to reevaluate 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 acknowledged that continuing the educational and testing period is not the right course of action. Therefore, CMS finalized its policy to rescind the regulations governing the program. While it has permanently paused 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 finalized its proposal for 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 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 finalized its proposal to maintain the in-home additional payment for COVID-19 vaccine administration under the Part B preventive vaccine benefit. The agency also finalized its proposal to extend the in-home 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. Providers and suppliers should continue to bill Medicare Part B for the additional payment for the in-home administration of COVID-19 vaccines. Beginning January 1, 2024, they will also be able to bill Medicare Part B for the in-home administration of pneumococcal, influenza and hepatitis B vaccines. The additional payment will be geographically adjusted based on the PFS GAF and annually updated by the CY 2024 MEI percentage increase. CMS finalized its proposal to limit the additional payment to one payment per home visit, even if multiple vaccines are administered at the same visit. Every vaccine dose that is furnished during a home visit will still receive its own unique vaccine administration payment.

Medicare Parts A and B Payment for Dental Services

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

Medicare Parts A and B pay for dental services in limited 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 finalized its proposal to codify previously finalized payment policies for dental services prior to or during head and neck cancer treatments, whether primary or metastatic. CMS also finalized its proposal 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. In February 2024, CMS will accept and consider public submissions for potentially analogous clinical scenarios under which Medicare payment could be made for dental services.

Caregiver Training Services

Key Takeaway: CMS finalized its proposal to pay physicians and NPPs 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 finalized its proposal 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 will pay for these services when furnished by a physician, NPP (nurse practitioner, clinical nurse specialist, certified nurse-midwife, physician assistant or clinical psychologist) or therapist (physical therapist, occupational therapist or speech language pathologist) under an individualized treatment plan or therapy plan of care.

Conclusion

The CY 2024 PFS final rule outlines how budget neutrality constraints continue to impact Medicare physician payment. These 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 4.6%, while the final CF will decline by about 3.37%. Stakeholders will likely again urge Congress 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. While the payment areas of the rule are particularly challenging this year, comments did seem to change many of CMS's initial quality proposals, delaying mandatory electronic CQM adoption in the MSSP and an increase in the MIPS performance threshold, both of which could have added to the financial and operational challenges facing physicians and other clinicians under the fee schedule.

For more information, contact: Jeffrey Davis, Leigh Feldman, Deborah Godes, Kayla Holgash, Rachel Hollander, Lauren Knizner, Marie Knoll, Kristen O'Brien, Rachel Stauffer, Devin Stone or Emily R. Curran (McDermott Will & Emery—Associate).