



CY 2024 Medicare Physician Payment Schedule and Quality Payment Program (QPP) Proposed Rule Summary

On July 13, 2023, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2024 Revisions to Payment Policies under the Medicare Physician Payment Schedule (MFS) and Other Changes to Part B Payment and Coverage Policies [proposed rule](#) (Docket number CMS-1784-P). The proposed rule, scheduled to be published in the August 7, 2023 issue of the Federal Register, includes proposals related to Medicare physician payment and the Quality Payment Program (QPP). If finalized, these policies will take effect on January 1, 2024, unless otherwise noted. Interested parties have a **60-day comment period**, which ends on September 11, 2023, to provide feedback and comments on the proposed rule. The American Medical Association (AMA) will continue analyzing the rule and develop comments during the 60-day comment period to address potential impacts and advocate for improvements, sharing a draft comment letter with the Federation in advance of this submission deadline.

This proposed rule encompasses several crucial provisions that could significantly impact Medicare physician payment and the QPP. Key proposals from the rule include:

1. **Reduction in Medicare Conversion Factor:** The proposed rule predicts a 3.36 percent reduction in the 2024 Medicare conversion factor, lowering it from \$33.8872 to \$32.7476. Additionally, the anesthesia conversion factor is proposed to be reduced from \$21.1249 to \$20.4370.
2. **Mitigation of Budget Neutrality Cuts from the Evaluation and Management (E/M) Add-on Code:** CMS has reduced the estimated utilization assumption of the new E/M add-on code, G2211, from 90 percent in the 2021 rule to 38 percent (initial implementation) and 54 percent (full adoption) in the 2024 proposal. Despite this reduction, the add-on code will still lead to additional across-the-board cuts due to budget neutrality requirements.
3. **Delay of Updated Medicare Economic Index (MEI) Weights:** CMS has postponed the implementation of updated MEI weights, which were finalized for CY 2023. The delay is in response to the need for continued public comment and the AMA's national study, the Physician Practice Information (PPI) Survey, to collect data on physician practice expenses.
4. **Increased Performance Threshold in the Merit-based Incentive Payment System (MIPS):** CMS is proposing to increase the performance threshold to avoid a penalty in the MIPS from 75 points to 82 points. This change is estimated to increase the number of MIPS eligible clinicians receiving penalties of up to -9 percent.
5. **Delay of Mandatory Electronic Clinical Quality Measure (eCQM) Adoption:** CMS is proposing to delay mandatory eCQM adoption by Medicare Shared Savings Program (MSSP) participants in 2024. Participants may continue to use the CMS Web Interface for reporting quality measures.

Payment Provisions

Conversion Factor and Specialty Impact

The 2024 Medicare conversion factor is proposed to be reduced by 3.36 percent from \$33.8872 to \$32.7476. Similarly, the anesthesia conversion factor is proposed to be reduced from \$21.1249 to \$20.4370. These cuts result from a -1.25 percent reduction in the temporary update to the conversion factor under current law and a negative budget neutrality adjustment stemming in large part from the adoption of an office visit add-on code, discussed below. Unfortunately, these cuts coincide with ongoing growth in the cost to practice medicine as CMS projects a 4.5 percent MEI increase for 2024.

The AMA has developed a specialty impact analysis that shows the combined impact of the budget neutrality proposals in the rule and the reduction to the conversion factor under current law. Note, to maintain budget neutrality in the 2024 MFS, CMS retained the balance in the work, practice expense (PE), and professional liability insurance (PLI) RVU pools, which in effect increased the PE and PLI RVU pools.

Physician practices cannot continue to absorb these increasing costs while their payment rates dwindle. This is why the AMA and our partners in organized medicine [strongly support](#) H.R. 2474, the Strengthening Medicare for Patients and Providers Act, which would provide a permanent, annual update equal to the increase in the MEI and allow physicians to invest in their practices and implement new strategies to provide high-value care. Visit the AMA's [Fix Medicare Now](#) site and join the fight for financial stability for physician practices to preserve access to care for Medicare beneficiaries.

Relative Values

CMS is proposing to accept 91 percent of the AMA/Specialty Society RVS Update Committee (RUC) recommendations for new/revised Current Procedural Terminology® (CPT®) codes and codes identified via the RUC's potentially misvalued services process. CMS is proposing to increase maternity services to incorporate increases to the hospital Evaluation and Management (E/M) services, consistent with the RUC recommendations to incorporate the E/M increases into post-operative office and hospital visits in codes with global periods.

Clinical Labor Pricing Update

CY 2024 will be the third year of transition of the clinical staff wage increases. This inflationary update is budget neutral within the practice expense relative values, impacting those services with higher cost supplies and equipment the most severely, as illustrated in the CMS impact analysis. CMS finalized a multi-year transition to mitigate the impact of payment changes due to the clinical labor pricing update. Over a span of 4 years, CMS finalized the implementation of the clinical labor update, gradually transitioning from existing prices to the updated prices, which will be fully effective in 2025.

Potentially Misvalued Services

For CY 2024, CMS received several commenters identified potentially misvalued services for review. CMS reviewed each of these comments and concluded that the practice expense for the physical therapy services should be evaluated. The RUC Health Care Professional Advisory Committee (HCPAC) Review Board will review these codes in January 2024.

E/M Visits

The CPT Editorial Panel and the RUC convened a workgroup that led the physician community in developing a new documentation and reporting mechanism for E/M visits. The changes provided administrative simplification in reporting and simultaneously led to increases in relative values and payments to E/M visits. Payment for office visits were increased in 2021 and the remaining families of E/M services, including hospital visits, were increased in 2023.

CMS argues that at least 38 percent of office visits warrant an additional increase to account for “additional resources associated with primary care or ongoing care related to a patient’s single, serious, or complex chronic condition, regardless of visit level.” The agency is proposing to implement G2211 *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care 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. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)*. CMS clarifies that it will not allow payment for G2211 when reported on the same date as an E/M visit reported with modifier -25. The implementation of G2211 will necessitate a -2.17 percent reduction to the Medicare conversion factor.

CMS requests comments on the future evaluation of E/M services. Despite the successful work of the CPT Editorial Panel and the RUC to achieve consensus within the medical community on the description and valuation increases to E/M and this additional proposal by CMS to further enhance payment for office visits, CMS responds to critics who continue to seek more involvement in decision-making related to the Medicare Physician Payment Schedule. The RUC, and the AMA, will present a strong response to CMS that the medical profession is the best source of information in describing the services performed by physicians and what is involved in the provision of these services.

Split (or Shared) Visits

In response to organized medicine advocacy, CMS is proposing another one-year delay of its policy requiring a physician to see the patient for more than half of the total time of a split or shared E/M visit in order to bill for the service. This policy was also paused in 2023 due to concerns that it would drastically disrupt team-based care and interfere with the way care is delivered in the facility setting as it does not consider medical decision-making by the physician. The longstanding CMS policy has been that the physician can bill for a split or shared visit if they perform a substantive portion of the encounter.

A split or shared visit refers to an E/M visit performed by both a physician and a qualified health care professional (QHP) in the same group practice in the facility setting where “incident to” billing is not available. Medicare pays physicians at 100 percent of the MFS rate, while QHPs are paid at 85 percent of the Physician Payment Schedule. Through calendar year 2024, physicians would continue to bill split or shared visits based on the current definition of substantive portion as one of the following: history, or exam, or medical decision-making, or more than half of total time. CMS stated that it will look for additional advice from CPT. The CPT Editorial Panel has approved revisions to the E/M guidelines that provide further definition in its release of the CPT 2024 publication.

MEI and the PPI Survey

CMS announces that the finalized 2017-based MEI cost weights will be delayed, pending the completion of the AMA’s PPI Survey. This delay responds to AMA Advocacy to continue to use physician practice cost survey data in determining the MEI cost weights and the criticism to the mechanisms used by CMS

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in computing these weights in earlier proposals. CMS notes that 2022 data from the Services Annual Survey will be available later in 2023 and they will continue to monitor these and other data sources as a contingency to the PPI Survey successful completion.

The AMA and Mathematica will formally launch the PPI Survey effort on July 31, 2023. [The PPI Survey](#) supported by [173 healthcare organizations](#), will provide more than 10,000 physician practices with the opportunity to share their practice cost data and number of direct patient care hours provided by both physicians and qualified healthcare professionals. A coalition of other non-MD/DO organizations is also working with Mathematica to administer a similar study of their professions. These surveys will be in the field through April 2024. Data would be shared with CMS in early 2025 for the 2026 Medicare Physician Payment Schedule rulemaking process. The AMA has called on the Federation to communicate to their members the importance of participating in this effort.

Telehealth and Remote Monitoring

CMS is implementing the telehealth flexibilities that were included in the Consolidated Appropriations Act 2023 (CAA) by waiving the geographic and originating site requirements for Medicare telehealth services through the end of CY 2024. By doing so, patients all across the country will retain the ability to access telehealth services, particularly from their own homes. Per the CAA, CMS is extending payment for the CPT codes for audio-only telephone visits as well as all other services that were on the 2022 Medicare Telehealth Services List through 2024 and is delaying in-person visit requirements for telemental health services. For 2024, CMS is further proposing to 1) continue paying for telehealth services provided to patients in their homes at the non-facility payment rate, which is the same rate as in-person office visits; 2) lift the frequency limits on telehealth visits for subsequent hospital and skilled nursing facility visits; and 3) allow direct supervision to be provided virtually. Proposed policies on virtual supervision of residents are discussed below.

Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) Services

CMS also outlines the post-COVID-19 public health emergency (PHE) Medicare payment policies for the CPT codes for RPM and RTM, noting that these services can only be provided to established patients, that the codes describing monthly monitoring can be reported only if a minimum of 16 days of data have been collected, and that the services may be reported for months when care management or surgical global services are also being reported. CMS also stated that these codes should be reported only once during a 30-day period, regardless if multiple medical devices are provided to a patient, and that they cannot be billed by more than one physician or other health professional in a month.

RPM and RTM services furnished in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

In response to stakeholder requests, CMS is proposing a significant change to its reimbursement policies for FQHCs and Rural Health Clinics RHCs. The proposal aims to expand payment coverage for RPM and RTM services provided in FQHCs and RHCs.

Under this new proposal, FQHCs and RHCs will be allowed to report RPM and RTM services under the existing general care management code, G0511. This code currently covers general care management services, involving 20 minutes or more of clinical staff time dedicated to chronic care management services or behavioral health integration services, under the direction of an RHC or FQHC practitioner (such as a physician, nurse practitioner, physician's assistant, or certified nurse's assistant). By including

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RPM and RTM services within this code, CMS seeks to enhance care management in these healthcare settings, aligning with recent policies aimed at improving patient outcomes.

To implement this proposed policy effectively, CMS plans to adjust the reimbursement rate for G0511. The adjustment will be made based on a weighted average utilization of all services that fall under this code. This approach ensures fair and appropriate compensation for the various services provided by FQHCs and RHCs under the expanded coverage of G0511.

Request for Information on Digital Therapies

As part of its comprehensive inquiry into digital therapies, CMS is actively seeking input from interested parties to gain valuable insights into the current landscape of coverage and payment policies for RPM and RTM. The agency aims to better comprehend the existing opportunities and challenges associated with these services. Feedback provided will play a crucial role in shaping potential provider education, program guidance, and even future rulemaking decisions.

Supervision of Residents in Teaching Settings

In the 2021 MFS final rule CMS finalized new guidelines regarding the presence of teaching physicians during services involving residents. According to these guidelines, after the conclusion of the COVID-19 PHE, teaching physicians are allowed to fulfill the requirement of being present for key or critical portions of services through a virtual presence. However, this provision applies only to services that are furnished in residency training sites located outside of a metropolitan statistical area (MSA) as defined by the Office of Management and Budget (OMB). Conversely, within an MSA, for services to be eligible for payment under the MFS, CMS stipulated that teaching hospitals must ensure a physical presence of the teaching physicians during the key portion of the service that is being provided by residents.

In response to concerns about sudden shifts back to pre-COVID-19 PHE policies, CMS is considering expanding this remote supervision option. CMS is now proposing to allow the teaching physician to have a virtual presence in all teaching settings in clinical instances when the service is furnished virtually (for example, a 3-way telehealth visit, with all parties in separate locations) through 2024. CMS is seeking comments and information to help them consider how telehealth services can be furnished in all residency training locations beyond December 31, 2024, to include considerations of what other clinical treatment situations are appropriate to permit the virtual presence of the teaching physician. Additionally, CMS is seeking information on how the teaching physician's virtual presence could continue to support patient safety, while meeting the clinical needs for all patients, and ensure burden reduction without creating risks to patient care or increasing opportunities for fraud.

Services Addressing Health-Related Social Needs (Community Health Integration Services, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation (PIN) Services

CMS is proposing to pay separately for Community Health Integration, SDOH Risk Assessment, and PIN services to account for resources when clinicians involve community health workers, care navigators, and peer support specialists in furnishing medically necessary care. While these care support staff have been able to serve as auxiliary personnel to perform covered services incident to the services of a Medicare-enrolled billing physician or practitioner, the services described by the proposed codes are the first that are specifically designed to describe services involving community health workers, care navigators, and peer support specialists. CMS is also clarifying that the auxiliary personnel may be employed by

Community-Based Organizations (CBOs) as long as there is the requisite supervision by the billing practitioner for these services, similar to other care management services. Also, CMS is proposing coding and payment for SDOH Risk Assessments to recognize when practitioners spend time and resources assessing SDOH that may be impacting their ability to treat the patient. CMS is also proposing to add the SDOH Risk Assessment to the annual wellness visit (AWV) as an optional, additional element with an additional payment. In addition, CMS is proposing codes and payment for SDOH risk assessments furnished on the same day as an E/M visit.

Geographic Practice Cost Indices (GPCIs)

For 2024, CMS is not making any proposed changes to the GPCIs. The rule notes, however, that the legislation establishing a 1.0 floor on the work GPCI will expire at the end of 2023, so the GPCIs and summarized geographic adjustment factors for each locality that are displayed in Addenda D and E of the rule do not reflect the work GPCI floor. The rule also notes that policies affecting the locality definitions for California which were finalized in 2023 rulemaking will be operationalized in 2024.

Skin Substitutes

CMS is continuing to seek comments about how best to establish appropriate payment for skin substitute products under the MFS. In addition, CMS is seeking comments about cost-gathering approaches to establish direct PE input for skin substitute products and to develop payment rates for physician services that involve furnishing skin substitute products. The agency is also considering how to account for these products' variability and resource costs, especially as new products increasingly become available. The AMA is pleased that CMS is not proposing to change the terminology of these products to "wound management," as we raised concerns that this would differ from CPT nomenclature and cause confusion and inconsistent reporting.

In comments during a CMS Town Hall about skin substitutes, the AMA reiterated our long-standing position that CMS should separately identify and pay for high-cost supplies that are greater than \$500 using appropriate Healthcare Common procedure Coding System (HCPCS) codes. The AMA believes that the pricing of these supplies should be based on a transparent process, where items are reviewed annually and updated.

Additional Payment for In-Home Preventive Vaccine Administration Services

CMS is proposing to maintain the additional payment for in-home administration of the COVID-19 vaccine (HCPCS code M0201) beyond the end of the COVID-19 PHE and to extend the payment for in-home administration of three additional preventive vaccines – the pneumococcal, influenza, and hepatitis B vaccines. The in-home additional payment amount is \$36.85 in 2023, and CMS has previously finalized that it will be updated annually by the percentage increase in MEI, which is projected to be 4.5 percent for 2024, and geographically adjusted.

CMS' analysis of the use of this code found that it was being billed significantly more frequently for patients who are harder to reach and that may be less likely to otherwise receive these preventive benefits. Between June 2021-June 2022, those 85 years of age and older were over three times more likely than younger beneficiaries to have received an in-home COVID-19 vaccination, and persons who are dual eligible for both Medicare and Medicaid were more than twice as likely than those who are not dual eligible to have received a COVID-19 vaccine provided in their home.

The agency is proposing to limit the additional payment to one payment per home visit, even if multiple vaccines are administered during the same home visit. CMS emphasized that every vaccine dose that is furnished would still receive its own unique vaccine administration payment. The agency would also extend the requirements for billing HCPCS code M0201, including that the patient has difficulty leaving the home, to the administration of the additional preventive vaccines, though the agency will broaden the requirements that currently reference COVID-19 specifically.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Program

In response to concerns raised by the AMA, CMS is proposing to pause implementation of the AUC program and rescind the current program regulations due to issues with the claims-based reporting requirements for ordering and furnishing physicians. The AMA is glad that CMS heard our concerns about the burden of these requirements and their potential negative impact on beneficiary access to care. CMS also cited concerns that claims would be inappropriately denied, data integrity and accuracy would be lacking, and beneficiaries would potentially be financially liable for advanced diagnostic imaging services. The agency is also proposing to end the educational and operations testing period.

CMS acknowledged that many of the goals of the AUC program have been met by the Quality Payment Program (QPP) and other value-based care initiatives, including the Medicare Shared Savings Program, advances in electronic clinical quality measures (eCQMs) and interoperability requirements of the Certified Electronic Health Record Technology (CEHRT). Finally, the agency reiterated that clinical decision support tools can be beneficial in assisting with clinical decision making and encouraged their continued use in a manner that best serves physicians and their patients.

Medicare/Medicaid Enrollment

CMS is proposing a “stay of enrollment” that the agency could use to delay for 60-days revocation or deactivation of billing privileges for simple paperwork mistakes or missed deadlines. For the 60-day stay to be implemented, which is discretionary and will be determined by the agency on a case-by-case basis, the provider or supplier must be non-compliant with at least one enrollment requirement and CMS must ascertain that the provider or supplier can remedy the non-compliance via the submission of the appropriate paperwork (e.g. Form CMS-855). Providers or suppliers will not receive payments for services or items furnished to Medicare patients during the stay of enrollment.

Dental Services

CMS is proposing to cover additional dental services it considers integral to the successful outcome of a Medicare covered clinical service, specifically those used to identify, diagnose, and treat oral or dental infections in connection with certain cancer treatments including chemotherapy, Chimeric antigen receptor (CAR) T-Cell therapy, and high-dose bone modifying agents. The agency is proposing to clarify that eligible dental services related to treatments for head and neck cancer may occur in an inpatient or outpatient setting (and would be payable under Medicare Part A or Part B as appropriate) and may occur prior to the initiation of, or during treatment for head and neck cancer, whether primary or metastatic, regardless of site of origin and/or initial modality of treatment. CMS seeks comment on whether additional dental services should be added, specifically those considered inextricably linked to cardiac intervention services and treatment for Sickle Cell Disease, Hemophilia, auto-immune conditions, Diabetes, and other chronic conditions. The agency is proposing to clarify that no Medicare payment should be made for dental services not immediately necessary to eliminate or eradicate the infection, so dental implants, crowns, or dentures would be ineligible. Finally, CMS seeks comment on a range of topics including overlap of dental coverage plans/third-party payers.

Diabetes Services

Diabetes Screening and Definitions

Following years of AMA advocacy, CMS is proposing to cover the hemoglobin A1C (HbA1c) test for diabetes and prediabetes screening purposes, as consistent with updated United States Preventive Services Task Force recommendations. The agency is also proposing to align screening frequency caps at twice within a rolling 12-month period and simplify the definition of diabetes by removing codified clinical test requirements, which is required for some but not all diabetes services.

Diabetes Self-Management Training (DSMT) Services

Regarding DSMT services, CMS is proposing to clarify that a registered dietitian, registered nurse, or pharmacist is permitted to provide educational DSMT services on a solo basis as part of an accredited DSMT entity; however, only a RD or nutrition professional is authorized to bill Medicare on behalf of a DSMT entity. Except for DSMT services furnished through an accredited DSMT entity, Registered dietitians and nutrition professionals can be paid for DSMT services only when they have directly performed the service. CMS is further proposing that practitioners currently able to report DSMT services furnished in person by the DSMT entity may also report DSMT telehealth services, including when performed by others within the DSMT entity. CMS is additionally proposing to allow one-hour trainings (initial or follow up) required for insulin-dependent beneficiaries to be provided via telehealth.

Medicare Diabetes Prevention Program (MDPP)

Regarding the MDPP, CMS is proposing to extend several COVID-19 PHE flexibilities an additional four years, including alternatives for in-person weight measurements and eliminating the cap on the number of services that may be provided virtually (though suppliers must continue to maintain in-person recognition). Additionally, CMS is proposing to allow up to 22 sessions during the 12-month core services period, convert to a hybrid fee-for-service and weight loss payment structure, align recognition with CDC's Diabetes Prevention Recognition Program, and make several definitional changes for added clarity.

Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Expansion of Supervising Practitioners

CMS is proposing to revise §§ 410.47 (PR) and 410.49 (CR/ICR) to expand to the types of practitioners who may supervise PR, CR and ICR programs to include a physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist (CNS). CMS argues that these changes are needed to fulfill the statutory requirement in section 51008 of the Bipartisan Budget Act of 2018 (Pub. L. 115-123, enacted February 9, 2018) (BBA of 2018) effective January 1, 2024.

Advancing Access to Behavioral Health Services

Implementation of Section 4121(a) of the Consolidated Appropriations Act, 2023

Section 4121(a)(1) of the Consolidated Appropriations Act of 2023 amended section 1861(s)(2) of the Act by adding a new benefit category under Medicare Part B to include marriage and family therapist (MFT)

services and mental health counselor services (MHC). Consistent with the changes to the statute, CMS is proposing to create two new regulation sections at § 410.53 and § 410.54 to codify the coverage provisions for MFTs and MHCs, respectively. This includes proposed definitions for MFTs and MHCs and that the services must be of a type that would be covered if they were furnished by a physician or as an incident to a physician's professional service and must meet certain requirements. CMS is also clarifying that services furnished by a marriage and family therapist to an inpatient of a Medicare participating hospital do not fall under the Medicare Part B benefit category for MFT services. CMS is additionally proposing to amend § 410.10 to add marriage and family therapist services and mental health counselor services to the list of included medical and other health services and to amend § 410.150 to add marriage and family therapists and mental health counselors, to the list of individuals or entities to whom payment is made. CMS is also proposing to add that the payment amount for CSW, MFT, and MHC services is 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for clinical psychologist services under the MFS. CMS is also proposing to add MFTs and MHCs to the list of practitioners who are eligible to furnish Medicare telehealth services at the distant site. Furthermore, under this proposal, Addiction Counselors would be considered Mental Health Counselors and would be eligible to enroll and bill Medicare for MHC services if they meet the necessary requirements. Moreover, CMS is proposing to change corresponding descriptor and billing codes to help enact these proposed changes.

Coding Updates

CMS is proposing to modify the descriptor for HCPCS code G0323 to enable MFTs and MHCs, along with Clinical Psychologists (CPs) and CSWs, to bill for monthly general behavioral health integration services, specifically when the respective practitioner's services serve as the focal point of care integration. CMS is also inviting feedback regarding other potential HCPCS codes that might need updates to facilitate MFTs and MHCs in billing for services detailed in the code descriptor.

Implementation of Section 4123 of the Consolidated Appropriations Act, 2023

Under the provisions of Section 4123 of the Consolidated Appropriations Act, 2023, certain changes are to be implemented regarding psychotherapy for crisis services under the MFS. A new paragraph (12) is added to section 1848(b) of the Act, mandating the establishment of new HCPCS codes for crisis services provided in non-office settings where the non-facility rate for such services applies under the MFS. The payment amount for these services should be set at 150 percent of the MFS amount applicable to non-facility sites of service identified by HCPCS codes 90839 and 90840.

To comply with the statutory requirements, the CMS is proposing the creation of two new G-codes that describe psychotherapy for crisis services in these non-facility sites of service:

1. GPFC1: Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes; and
2. GPFC2: Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); each additional 30 minutes.

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These new G-codes are applicable to any non-facility place of service except the physician's office, and the definition of "non-facility place of service" is expanded to include an individual's home, even if it's temporary lodging.

To determine the RVUs for the new G-codes, CMS is proposing to calculate values by multiplying the RVUs of CPT codes 90839 and 90840 by 1.5, as per the statutory requirement. Additionally, the expenditures for the new HCPCS codes will not be factored into MFS budget neutrality adjustments.

Health Behavior Assessment and Intervention (HBAI) Services

CMS is proposing to extend the ability to bill for HBAI services, which include CPT codes 96156, 96158, 96159, 96164, 96165, 96167, 96168, and any future related codes, to CSWs, MFTs, and MHCs, alongside CPs. HBAI CPT codes are designed to cover psychological evaluations and treatments and address psychological, behavioral, emotional, cognitive, and interpersonal factors that complicate the primary medical diagnosis and treatment of a patient. Presently, CPs are allowed to charge Medicare for HBAI services. MFTs, MHCs, and CSWs also have the required education and training to address the above-mentioned psychological and related factors tied to physical health conditions.

Adjustments to Payment for Timed Behavioral Health Services

CMS recognizes a critical shortage of behavioral health clinicians nationwide, leading to significant delays for individuals needing medical services. In response, the agency is evaluating its methodologies for developing relative values under the MFS for behavioral health services, ensuring that the values applied accurately mirror the resources required in delivering these services. Given that behavioral health services are centered around conversational interactions rather than physical ones, it may be possible that the work RVUs assigned to these services might be undervalued compared to other medical services. The valuation is largely dependent on the practitioner's effort and time-based codes remain static in efficiency irrespective of the practitioner's experience.

To increase the accuracy of valuation for timed psychotherapy services, CMS is proposing to implement an add-on code calculated by the add-on code for valuation for inherent complexity for office/outpatient E/M services discussed earlier. In 2024, the agency intends to adjust the work RVUs for the psychotherapy codes payable under the MFS. This adjustment will be based on the discrepancy in total work RVUs for office/outpatient E/M visit codes billed with the proposed inherent complexity add-on code and the total work RVUs for visits not billed with the add-on code. This results in an estimated increase of 19.1 percent for work RVUs for these services, which CMS is proposing to introduce over a 4-year transition period. The agency believes that these proposals would offset any potential negative valuation impact for psychotherapy services arising from the redistributive impacts if the inherent complexity add-on for E/M visits is finalized. CMS encourages feedback on these proposals and ideas to enhance MFS valuation processes for these and similar services.

CMS also refers to the CY 2018 MFS final rule (82 FR 52999) where a minimum non-facility indirect PE RVU was applied to outlier codes over a 4-year transition period from 2018 to 2021. The agency is seeking feedback on whether this minimum value adjustment sufficiently accounted for the resources involved, if additional adjustments should be considered, and if further changes should be implemented over another 4-year transition.

Supervision Requirements for Behavioral Health Services furnished at RHCs and FQHCs

Under the MFS, CMS mandates a general supervision level for behavioral health services provided by auxiliary personnel. However, such services continue to be under the direct supervision provisions in RHCs and FQHCs. Aligning with the supervision criteria of the MFS, CMS is proposing that auxiliary personnel at RHCs and FQHCs could also provide behavioral health services under the general supervision framework.

Hospice: Changes to the Hospice Conditions of Participation (CoPs)

The CAA, 2023 established that the interdisciplinary group in hospice care must include at least one CSW, MFT, or MHC. CMS is proposing amendments to the Hospice Conditions of Participation (CoPs) at §418.56, enabling the inclusion of CSWs, MHCs, or MFTs as part of the interdisciplinary team. Additionally, changes are proposed to hospice staff qualifications at §418.114(c) to incorporate credentials for an MFT and an MHC.

CMS elaborated on the similarities and dissimilarities among CSWs, MFTs, and MHCs. They underscored the necessity for the hospice to evaluate and decide on the care and services that most appropriately align with the patient's preferences and needs.

Treatment of Opioid Use Disorder (OUD)

In the 2023 MFS final rule, CMS finalized the rates for bundled episodes of care for OUD services provided through Opioid Treatment Programs (OTPs) to reflect more resources devoted to psychotherapy. For 2024, CMS is proposing a parallel increase in the bundled episode payments for office-based OUD treatment. The office-based OUD bundled payment services are included on the Medicare Telehealth List and audio-only interactions can meet the Medicare requirements for reporting these services. For OUD services provided through OTPs, CMS is proposing to extend its current policy allowing periodic assessments to be provided via audio-only communications through the end of calendar year 2024. CMS also indicates that it has included proposals related to provision of intensive outpatient program services by OTPs in the outpatient hospital proposed rule.

Electronic Prescribing of Controlled Substances (EPCS)

CMS is not proposing any substantive changes to its EPCS program policies for calendar year 2024. The agency previously finalized a policy to enforce compliance with Medicare EPCS requirements by sending a letter to physicians who are not in compliance explaining the need for them to take action. The current rule indicates that CMS is proposing to continue this same enforcement policy in future years. Other changes discussed in the rule involve administrative details such as term definitions and alignment between EPCS emergency circumstances waivers and similar waivers administered by CMS for other programs such as MIPS.

Coding and Payment for Administration of Complex Non-Chemotherapy Drugs

CMS is seeking comment on policies regarding coding and payment for the administration of complex non-chemotherapy drugs paid under Medicare Part B. CMS has noted that payment for the administration of these drugs is becoming increasingly inadequate due to existing coding and billing guidelines for services that are similarly complex and clinically intensive to chemotherapy and complex biologic

administration. The agency is seeking input on appropriate coding and payment policies and if CMS should revise current guidelines.

Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs)

For performance year 2024 and subsequent performance years, CMS is proposing a new collection type for Medicare Shared Savings Program (MSSP) participants to report their quality measures- Medicare clinical quality measures (Medicare CQMs). The Medicare CQM collection tool would serve as a transition collection type to help ACOs build the infrastructure to report the all payer/all patient MIPS CQMs and electronic clinical quality measures (eCQMs). If reporting quality for MSSP through the Medicare CQM collection tool, CMS will provide ACOs with the list of beneficiaries who are eligible for Medicare CQMs within the ACO, upon the ACO's request. CMS anticipates the list of beneficiaries eligible for Medicare CQMs to be shared once annually, at the beginning of the quality data submission period.

In addition, in 2024 ACOs would continue to have the option to report quality data utilizing the CMS Web Interface measures, eCQMs, and/or MIPS CQMs collection types. However, starting in performance year 2025, ACOs would no longer have the option to report the CMS Web Interface measures and must report quality utilizing the eCQMs, MIPS CQMs, and/or Medicare CQMs collection types.

CMS is proposing to sunset the Shared Savings Program CEHRT threshold requirements and require clinicians to report Promoting Interoperability (PI) measures as either: (1) MIPS eligible clinicians, QPs, and partial QPs participating in an ACO (as an individual, group, or virtual group); or (2) an ACO as an APM entity for performance years beginning after January 1, 2024. CMS is also proposing to modify the definition of CEHRT to incorporate the Office of the National Coordinator for Health IT (ONC) new definition of Base EHR and its certification criteria for Health information technology (health IT) as proposed in its [recent HTI-1 regulation](#).

Regarding beneficiary assignment, CMS is proposing to add several new primary care services to be used for assignment, as well as add a new third "step" with an expanded assignment window of 24 months, which would apply to all ACOs starting in 2025. The agency expects this will result in slightly increased populations of both assigned and assignable beneficiaries.

CMS is proposing several new benchmarking refinements designed to encourage sustained participation and protect ACOs serving medically and/or socially complex populations, including eliminating the impact of negative regional adjustments on an ACO's financial benchmark altogether.

CMS is proposing several refinements to Advance Investment Payment (AIP) policies, including allowing AIP ACOs to advance to risk-bearing tracks beginning in performance year three or opt to early renew after two years and carry forth their AIP balance into their new performance contract. ACOs would also be subject to new reporting requirements concerning how AIPs are spent and would be prohibited from using AIPs to fund repayment mechanisms or repay shared losses.

Finally, CMS seeks comment in several key areas, including a potential higher-risk track, possible refinements to the three-way blended benchmark, MVP reporting for MSSP specialists, and strategies to promote collaboration with community-based organizations to address health-related social needs.

Merit-based Incentive Payment System (MIPS)

Performance Threshold

CMS is proposing to increase the performance threshold to avoid a MIPS penalty from 75 points to 82 points. CMS estimates this would result in approximately 54 percent of MIPS eligible clinicians receiving a penalty of up to -9 percent, as discussed in more detail below. MIPS payment adjustments apply two years after the performance period. Bonuses and penalties from the 2024 performance period would apply to payments in 2026.

The AMA will strongly oppose increasing the threshold and is alarmed that CMS would propose an increase that results in a significant increase in physicians being penalized by MIPS, as the program has been largely paused since 2019 due to the significant disruptions caused by the COVID-19 pandemic. [Research](#) continues to show that MIPS is unduly burdensome; disproportionately harmful to small, rural, and independent practices; exacerbating health inequities; and divorced from meaningful clinical outcomes. The AMA is also [urging](#) Congress to make statutory changes to improve MIPS and address these fundamental problems with the program.

MIPS Value Pathways (MVP)

CMS continues to signal their intent that MVPs are the future of MIPS. To further this vision, CMS is proposing five new MVPs for the 2024 performance year, along with revisions to the previously finalized MVPs. Specifically, CMS is proposing to consolidate the previously finalized MVPs, Promoting Wellness MVP and Optimizing Chronic Disease Management MVP into a single primary care MVP.

The five newly proposed MVPs are:

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

CMS is also proposing several changes to its scoring policies for subgroups, which is a reporting option for MVPs only. Specifically, the agency is proposing that it would not calculate a facility-based score at the subgroup level. CMS would continue to calculate a facility-based score in traditional MIPS and assign the higher of the two final scores. Subgroups would receive their affiliated group's complex patient bonus, if applicable. In addition, subgroups would only receive reweighting based on any reweighting applied to its affiliated group. Finally, CMS is proposing to allow subgroups to submit a targeted review beginning with the 2023 performance period.

Quality Performance Category

CMS is proposing changes to the quality measure inventory list which will bring the total number of quality measures to 200 for the 2024 performance period. Importantly, this figure does not encompass QCDR measures, as they are approved independently from the rulemaking process.

The proposed changes include:

- The inclusion of 14 new quality measures, one of which is a composite measure. Also among the newly introduced measures, seven are of high priority, including four patient-reported outcome measures;
- The elimination of 12 quality measures from the MIPS quality measure inventory;
- The partial elimination of 3 quality measures from the MIPS quality measure inventory. These measures are suggested for removal from traditional MIPS, but will be kept for MVP use only; and
- Significant modifications to 59 existing quality measures.

Unfortunately, CMS is proposing no changes to the previously finalized quality measure data completeness thresholds for the 2024 or 2025 performance periods and maintains them at 75 percent. In addition, CMS is proposing to increase the quality measure data completeness threshold to 80 percent starting with the 2027 performance period.

Cost Performance Category

The Cost Performance Category accounts for 30 percent of physicians' MIPS final scores. CMS is proposing to add five new episode-based cost measures with a 20-episode case minimum, which are Psychoses and Related Conditions, Depression, Heart Failure, Low Back Pain, and Emergency Medicine. CMS is also proposing to remove one episode-based cost measure – Simple Pneumonia with Hospitalization. CMS is proposing to calculate the improvement score for the cost performance category at the category level, as opposed to the individual measure level, and without statistical significance. Finally, CMS is proposing a maximum improvement score of 0 points for the 2022 performance period and 1 point for the 2023 performance period.

Improvement Activities (IA) Performance Category

CMS is proposing to add five new improvement activities, modify an existing improvement activity, and remove three previously adopted improvement activities, as summarized in Appendix 2. The new activities include Human Immunodeficiency Virus (HIV) prevention services, cervical cancer screening and management decision support tools, behavioral/mental health and substance use screening and referrals for pregnant and post-partum women and older adults, and quality improvement as part of the MVP Program. CMS is further proposing to clarify that in order to be awarded half credit for the IA category for participation in an APM, a MIPS eligible clinician or group must submit data for both the Quality and PI performance categories or attest to having completed at least one improvement activity. CMS will also not award half credit if it approves a hardship exception or reweighting request affecting the IA category.

Promoting Interoperability (PI) Performance Category

CMS is proposing to increase the performance period for this category to a minimum of any continuous 180-day period within CY 2024. CMS wants MIPS eligible clinicians to have a more accurate understanding of their overall and move towards reporting on a full years' performance, starting with this incremental increase.

Third Party Intermediaries

Health IT Vendors

CMS is proposing to remove health IT vendors from the definition of third-party intermediary to directly report under MIPS beginning with the CY 2025 performance period. Vendors are not precluded from assisting MIPS eligible clinicians with reporting under the program. Under this proposal, vendors that are submitting MIPS data to the agency will now have to meet the requirements of a qualified registry or QCDR. In addition, vendors could also work with clinicians through the sale and support of health IT that permits the clinician or group to submit the data, outside of any registry or QCDR requirements.

Public Reporting of Cost Measures

CMS is proposing to modify existing policy about publicly reporting procedure utilization data on individual clinician profile pages by incorporating Medicare Advantage data on procedure volumes. CMS is also exploring publicly reporting cost measures beginning with the CY 2024 performance period/2026 MIPS payment year.

Advanced Alternative Payment Models (APMs)

Absent Congressional action, the 3.5 percent lump sum APM Incentive Payment is scheduled to expire at the end of the 2023 performance year (2025 payment year). Beginning in the 2024 performance year (2026 payment year), under current law Qualified APM Participants (QPs) will instead receive a positive 0.75 percent CF update, while non-QPs will receive a 0.25 percent CF update. Also under current law, QP thresholds are scheduled to increase by the amounts listed in the table below. The AMA supports legislation that would extend the APM Incentive Payment, freeze the QP payment threshold at its current level, and replace these differential CF updates with an inflation-based update for all physicians.

	Payment Amount Method		Patient Count Method	
	QP	Partial QP	QP	Partial QP
2023 Performance	50 (25)	40 (20)	35 (20)	25 (10)
2024 Performance	75 (25)	50 (20)	50 (20)	35 (10)

** Parentheses indicate the separate Medicare minimum required under the All-Payer Combination Option*

CMS is proposing to calculate QP determinations at the individual, rather than APM Entity level starting next year following previous AMA feedback in support of this change. The agency would do so by making a separate calculation for each National Provider Identifier (NPI) associated with an Advanced APM, then calculate a threshold score for each NPI based on all covered professional services (not only E/M services) furnished across all Tax Identification Numbers (TINs) to which the eligible clinician reassigned their billing rights. The agency believes this change will mitigate perverse incentives for APM Entities to exclude certain types of clinicians including specialists from participation lists for attribution reasons.

Finally, CMS is proposing to terminate the current 75 percent CEHRT use requirement and allow the definition of CEHRT for purposes of Advanced APMs to vary based on which specific CEHRT functionalities are relevant to each particular model to provide additional flexibility and improve the clinical relevance of CEHRT.

Definitions

Attestation

CMS is proposing to make a change for clarity to the definition of attestation. CMS wants to ensure that clinicians understand that attestation means a secure mechanism that a MIPS eligible clinician, group, or subgroup may use to submit the required data for the Promoting Interoperability or the improvement activities performance categories of MIPS.

CEHRT

CMS is proposing a change beginning with CY 2024 to the definition of CEHRT to mean EHR technology that meets ONC's 2015 Edition Base EHR definition and is certified as meeting other additional health IT certification criteria adopted or updated that are determined applicable to that APM. CMS is also proposing to end the current 75 percent CEHRT use requirement with the CY 2023 QP performance period and to add the requirement that to be considered an Advanced APM, the APM must require all eligible clinicians in each participating APM Entity or hospital to use CEHRT that meets the newly proposed definition granting more flexibility.

Projected 2024 MIPS Participation and 2026 Payment Adjustments

CMS estimates that 820,047 physicians and qualified health professionals will be MIPS eligible in the 2024 performance period. CMS projects an increase in the number of MIPS eligible clinicians receiving a penalty from 37 percent to 54 percent due to the proposed increase in the performance threshold from 75 points in 2023 to 82 points in 2024. The average penalty would be -2.40 percent and the maximum would be -9 percent. Notably, solo practitioners and physicians in practices with fewer than 100 eligible clinicians are more than 60 percent likely to face a MIPS penalty, whereas groups with 100 or more eligible clinicians are more likely to receive a bonus than a penalty.

MIPS penalties are redistributed as bonuses to high scorers. Due to the expected increase in penalties creating a larger pool to fund bonuses, CMS estimates that the average positive payment adjustment would be 3.35 percent and the maximum would be 8.82 percent. Overall, CMS expects to redistribute \$8.9 million in MIPS.

Helpful links:

- The text of the proposed rule can be accessed [here](#)
- The CMS press release is available [here](#)
- The CMS fact sheet is available [here](#)
- The CMS fact sheet on the 2024 Quality Payment Program is available [here](#)
- The CMS fact sheet on Medicare Shared Savings Program is available [here](#)