Summary of the CY 2024 Medicare Physician Fee Schedule Final Rule

On November 2, 2023, the Centers for Medicare and Medicaid Services (CMS) released the CY 2024 Medicare Physician Fee Schedule (MPFS) final rule. This regulation also impacts the Quality Payment Program (QPP). CMS released accompanying fact sheets on the MPFS, Medicare Shared Savings Program, and QPP changes. The provisions in the final rule will take effect on January 1, 2024, except where otherwise specified. The AAFP provided comprehensive comments on the proposed regulation.

Finalized Provision	AAFP Analysis	AAFP Recommendations
Conversion Factor & Estimated Impact on Family Medicine		
The 2024 conversion factor is $32.7442, which is 3.4% lower than the 2023 conversion factor.	Negative	The AAFP has continuously raised significant concerns with recent year over year conversion factor reductions and the increasing inadequacy of Medicare payment rates. We're calling on Congress to stop these annual payment reductions.
The AAFP estimates aggregate allowed charges for family medicine will increase by about 2% in 2024.	Positive	Most of the estimated increase in allowed charges for family medicine can be attributed to the finalization of the G2211 add-on code.
CMS will continue to update clinical labor pricing as part of its practice expense relative value unit methodology in CY 2024.	Positive	The AAFP supports CMS' plan to further update clinical labor pricing, which will help ensure Medicare physician payment rates more appropriately account for the costs of hiring and retaining clinical staff.
Evaluation and Management (E/M) Visits		
The G2211 add-on code for visit complexity is finalized for implementation and separate payment.	Positive	The AAFP has strongly advocated for the full implementation of the G2211 add-on code in 2024, as we believe it is an incremental but meaningful step toward more appropriately valuing and paying for comprehensive, longitudinal primary care.
G2211 will not be allowed when the base E/M code has modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same	Negative	The AAFP advocated to allow use of G2211 with a problem-oriented E/M code when that E/M code is done

Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service) appended		with a Medicare Annual Wellness Visit, which requires appending modifier 25 to the E/M code.
For 2024, CMS finalized a revised definition of "substantive portion" of a split (or shared) visit to reflect revisions to the Current Procedural Terminology (CPT) E/M guidelines. For Medicare, the "substantive portion" means more than half of the total time spent by the physician and non-physician provider performing the split (or shared) visit, or a substantive part of the medical decision making.	Positive	CMS alignment with CPT will avoid administrative burden associated with having different rules under Medicare.
Telehealth		
HCPCS code G0136 (administration of a standardized, evidence-based SDOH risk assessment tool) will be added to the telehealth services list on a permanent basis.	Positive	The AAFP supports this policy, which will help physicians be appropriately compensated as they work to address patients' health-related social needs.
For CY 2024, any service appropriately billed with place of service (POS) code 10 (Telehealth Provided in Patient's Home) will be paid at the non-facility rate (i.e., the same rate at which the service would have been paid if done in the physician's office).	Positive	The AAFP supports CMS' decision to pay for telehealth services billed with POS 10 at the non-facility rate. Paying at the non-facility rate will enable more physicians to continue offering telehealth services, which will improve patients' equitable access to care.
Telehealth services billed with POS 02 (Telehealth Provided Other than in Patient's Home) will be paid at the facility rate, which is less than what is paid for the same service done in the office.	Neutral	The AAFP advocates for coverage and payment policies that support patients' and clinicians' ability to choose the most appropriate modality of care. Paying telehealth services at the facility rate creates a barrier for office-based practices that do not receive the facility fee to provide telehealth services. However, the facility rate may be appropriate for other types of telehealth providers.
Through CY 2024, CMS will remove the frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultation services.	Positive	The AAFP supports removing the telehealth frequency limits for these visits and services through CY 2024. The AAFP recommended the permanent removal of these limitations.

In CY 2024, CMS will continue to define "direct supervision" to permit the immediate availability of the supervising physician through real-time audio and video interactive telecommunications.	Positive	The AAFP supports allowing direct supervision using real-time audio and video telecommunications technology. The AAFP recommended revising the policy on a permanent basis.
CMS will allow teaching physicians to have a virtual presence in all teaching settings in clinical instances when the service is furnished virtually (e.g., 3-way telehealth visits, with all parties in separate locations). Beginning in 2024, teaching physicians at residency training sites located outside of a MSA may meet the supervision requirements through interactive, audio and video telecommunications technology (does not include audio-only technology).	Positive	The AAFP advocated that teaching physicians should be allowed to have a virtual presence, regardless of whether the service is provided in-person or via telehealth. The AAFP also advocated for the permanent expansion of services allowed under the primary care exception.
CMS finalized several policies related to the statutory requirements of the *Consolidated Appropriations Act of 2023*. These include delaying the in-person visit requirement for mental and behavioral telehealth services until January 1, 2025; allowing patients to receive telehealth services from their home; adding licensed Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) to the list of eligible telehealth providers; and continued coverage of audio-only services included on the Medicare Telehealth Services list as of December 29, 2022 (including telephone E/M services [CPT codes 99441-99443]). Through CY 2024, CMS will also allow distant site practitioners to use their currently enrolled practice location instead of their home address when providing telehealth services from their home.	Positive	The AAFP supports these policies being finalized. The AAFP advocated against CMS requiring distant site practitioners to include their home address on Medicare enrollment paperwork related to rendering telehealth services, and we urge CMS to make the current extension permanent.
Behavioral Health		
Licensed MFTs and MHCs will be able to bill Medicare for services starting January 1, 2024, consistent with statute.	Positive	The AAFP has supported including MFTs and MHCs under Medicare to increase patient access to behavioral health care and reduce physician time and burden spent finding appropriate referrals for their patients when needed.

Timed behavioral health services— CPT code 99484 and HCPCS code G0323—will receive increased payment over a four-year transition.	Positive	The AAFP urged CMS to finalize this provision as proposed to ensure primary care physicians can newly integrate or sustain behavioral health integration in their practices.
Vaccines		
The higher COVID-19 vaccine administration rate will continue through 2024.	Positive	The AAFP urged the agency to confirm their intent to continue the enhanced payment through CY 2024.
The additional payment established for in-home administration of the COVID-19 vaccine is extended to all Part B preventive vaccines.	Positive	The AAFP supports this extension as the additional payment will increase access to Part B preventive vaccines for patients who have challenges leaving their home or live in assisted living facilities.
Appropriate Use Criteria Program (AUC)		
CMS indefinitely paused the AUC Program for re-evaluation and rescinded current program regulations.	Positive	The AAFP has repeatedly advocated for CMS to pause or delay implementation of the AUC Program and to rescind the current regulations, and we strongly support this decision.
Diabetes		
In CY 2024, non-fasting Hemoglobin A1C will be a covered diabetes screening test and patients may be screened for diabetes twice every 12 months.	Positive	The AAFP supported these proposals, which will make recommended screening more convenient.
Virtual flexibilities will be extended in the Medicare Diabetes Prevention Program (MDPP) through 2027.	Positive	The AAFP supported extending virtual sessions to increase equitable access to the Medicare Diabetes Prevention Program.
Electronic Prescribing of Controlled Substances (EPCS)		
Prescription renewals will count as an additional prescription in the EPCS Program compliance threshold calculation. Refills will not count as an additional prescription unless it is the first occurrence of that prescription's refill within a measurement year.	Positive	The AAFP supports CMS' decision to count prescription renewals—but not refills—toward the program's compliance threshold calculation. If each refill of a prescription counted towards the calculation, many prescribers who currently qualify for the small prescriber exception would have been at risk of no longer qualifying.

The “recognized emergency” and “extraordinary circumstances waiver” exceptions were updated to align with emergency policies in other CMS programs. Prescribers impacted by a recognized emergency exception would be excepted for the whole measurement year, not the length of the emergency.	Positive	The AAFP strongly supports these changes, which will streamline regulations and reduce administrative burden for family medicine practices.
Noncompliance notices will continue being issued to clinicians who don’t meet the 70% threshold for electronic prescribing of controlled substances under Medicare Part D, with no date given for imposing future financial penalties.	Positive	The AAFP has repeatedly advocated for CMS to maintain its current policy of issuing notices of noncompliance instead of financially penalizing clinicians who fail to meet this threshold, and we strongly support this decision.
Social Determinants of Health Screening		
Payment is finalized for an SDOH risk assessment using a standardized, evidence-based assessment tool with code G0136.	Positive	The AAFP believes physicians should receive resources to identify, monitor, and assess SDOH needs We agreed that the proposed 5-15 minute time estimate was appropriate for valuation. We supported the flexibility to choose any evidence-based assessment tool and to suggest (but not require) the use of Z-codes when documenting SDOH needs.
G0136 may be performed in conjunction with an Annual Wellness Visit (AWV), E/M or behavioral health visit.	Positive	We supported the proposal to add an additional payment to the AWV when an SDOH assessment is provided as an optional, additional element.
Community Health Integration (CHI) Services		
New coding and payment created for CHI services to address SDOH needs that are barriers to diagnosis or treatment of a problem identified in an E/M visit (G0019 for the first 60 minutes per month and G0022 for each additional 30 minutes). There is no limit on the total amount of time billed each month.	Positive	The AAFP supported the proposal to create new coding and payment to address identified social needs. We suggested allowing staff to bill in 20-minute increments for the first hour, but CMS believes that it will take at least one hour per month to address a patient’s SDOH needs.
Community Health Workers (CHWs) or other staff may provide CHI services incident to the physician who initiates CHI services during an E/M visit or AWV. Practices may contract with an external organization to	Positive	We supported the proposal to exclude inpatient/observation, ED, and SNF visits as a qualifying initiating visit to ensure CHI services are provided under the general supervision of a physician providing

provide CHI services if time spent providing services is documented in the patient's medical record.		longitudinal care. We agreed with the proposal to allow physicians to contract with community-based organizations to provide CHI services. We suggested CMS allow behavioral health visits to initiate CHI services, but CMS felt Principal Illness Navigation (PIN) services are more appropriate for referral by behavioral health (more on PIN below).
CHI services may be provided in-person or virtually, and because services may occasionally be provided without a patient's direct knowledge, patients must give verbal consent once a year to initiate service.	Positive	We urged CMS to accept verbal consent to reduce administrative burden and to allow all available communication modalities when providing CHI services.
Principal Illness Navigation (PIN) Services		
New coding and payment created for PIN services to help patients navigate serious, high-risk illnesses and facilitate needed social and emotional supports. "Serious, high-risk" illnesses are those expected to last at least three months and where the patient is at high-risk of hospitalization, acute decompensation, functional decline, and/or death.	Positive	The AAFP supports payment for patient navigation including the social aspects of serious illnesses.
Certified patient navigators, peer support specialists, or other auxiliary staff may provide PIN services under the general supervision of the practitioner who initiates PIN services during an E/M visit, AWV, psychiatric diagnostic evaluation (90791), or health behavior assessment and intervention (96156,-58, -59, 96164, -65, -67, -68). Like CHI services, PIN services may be contracted out to community-based organizations if incident-to billing requirements are met.	Positive	We supported the addition of the AWV to the list of eligible PIN-initiating visits. Because CMS includes severe mental illness and substance use disorder as conditions that meet the "serious, high-risk" criteria, they added psychiatric and behavior assessment related codes to the list of eligible initiating visits to ensure clinical psychologists would also be able to initiate PIN services.
There are two sets of codes for PIN services; the first (G0023-4) are broader and include care coordination tasks more common to navigating a medical illness, while codes G0016-7 are intended for peer support specialists who do not provide care coordination or patient assessment, and instead focus on supporting patients	Positive	We suggested CMS break up the first hour into three 20-minute increments to allow billing when the total time of PIN services delivered is less than one hour in a month; CMS reiterated the need for a one-hour service minimum per month. The additional set of codes for PIN services (G0016-7) addresses concerns voiced by the peer support

with behavioral health/substance use disorders. Codes G0023 and G0016 are for the first 60 minutes each month, and G0024 and G0017 are for each additional 30 minutes.		community that care coordination services are not in their scope.
Medicare Shared Savings Program (MSSP)		
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, Qualifying APM Participant (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 performance category score for the MIPS Promoting Interoperability performance category at the individual, group, virtual group, or APM Entity level.	Negative	The AAFP strongly opposed this proposal as it will add reporting and administrative burden to MSSP participants, which could negatively impact future recruitment and retention in the program.
CMS finalized modifications to the MSSP assignment methodology to add a third step which now includes an expanded window for beneficiary assignment. The expanded window is intended to better account for beneficiaries who receive primary care from nurse practitioners, physician assistants, and clinical nurse specialists during the 12-month assignment window and who received at least one primary care service from a primary care physician during the expanded 24-month window for assignment. This change goes into effect January 1, 2025.	Positive	We generally supported the expanded window of assignment; however, we urged CMS to ensure this change does not have the unintended consequence of assigning beneficiaries to clinicians in specialty care or non-primary care settings.
CMS finalized updates to how benchmarks are risk adjusted to align with the Medicare Advantage (MA) methodology, CMS-HCC risk adjustment model Version 28 (V28). V28 made several changes to the types of codes included and weighting of codes in the HCC calculation. CMS will use the same CMS-HCC risk adjustment model used in the performance year for all benchmark years, when calculating prospective HCC risk	Positive	We supported the alignment with the MA methodology while also calling for CMS to apply the methodology to all agreements, not just those with new agreements beginning in 2024 however CMS finalized the proposal as written.

scores to risk adjust benchmarks for agreement periods beginning on January 1, 2024, and in subsequent years.		
CMS finalized its proposal to establish the Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs). For PY 2024, ACOs may report via eCQMs, MIPS CQMs, CMS Web Interface, or Medicare CQMs. For 2024 and 2025, CMS will establish benchmarks for Medicare CQMs using performance year data. For performance year 2026 and beyond, CMS will use historical benchmarks.	Positive	The AAFP raised concerns about previous regulations that would have required ACOs to report all-payer measures. The all-payer requirement is often burdensome and ongoing challenges with data aggregation were creating barriers to successful adoption and performance.
Quality Payment Program		
CMS consolidated two primary care focused MVPs - Optimizing Care for Chronic Diseases and the Promoting Wellness MVPs – into a single Value of Primary Care MVP.	Positive.	The AAFP supported the consolidation of the primary care-focused MVPs into one MVP to help lessen the reporting burden on family physicians.
CMS eliminated the policy to allow subgroups to submit a separate reweighting application independent of its affiliated group. CMS may revisit this policy in the future.	Negative	The AAFP opposed this proposal and encouraged CMS to identify additional avenues that would allow subgroups to request reweighting independent of the affiliated group.
Due to operational challenges, CMS will assign the affiliated group's complex patient bonus to the subgroup.	Negative	The AAFP opposed this policy and believe it is important to calculate the complex patient bonus at the subgroup level given that the quality score is calculated at the subgroup level.
CMS will require the administration of the Spanish translation of the Consumer Assessment of Healthcare Providers and Suppliers (CAHPS) survey. The policy also applies to the MSSP.	Positive.	The AAFP supported the availability of the Spanish translation of CAHPS to ensure language accessibility and accurate reporting.
CMS is maintaining the data completeness threshold of 75% for performance years 2024, 2025, and 2026. CMS did not finalize its proposal to increase the data completeness threshold to 80% for the 2027 performance year.	Positive	The AAFP opposed increasing the data completeness threshold. There are still challenges with data collection and aggregation. Health information exchange and health information technology standards are not mature enough to fully support meaningful data sharing.

CMS finalized the addition of five new episode-based cost measures (Psychoses and Related Conditions, Depression, Heart Failure, Low Back Pain, and Emergency Medicine).	Neutral	Episode-based cost measures may be a more appropriate way to measure cost in the MIPS program and their inclusion in the program provides an alternative to the existing Total Per Capita Cost measure that the AAFP has long opposed. However, the AAFP expressed concern about measure overlap and the potential impact of double-counting costs when a physician is measured on multiple episode-based cost measures.
CMS is expanding the promoting interoperability category performance period from 90 continuous days to 180 continuous days. CMS is also revising the Safety Assurance Factors for the EHR Resilience Guides (SAFER Guides) measure to require eligible clinicians to attest “yes” to the annual self-assessment.	Negative	The AAFP opposed both proposals. We do not believe an expanded performance period is the appropriate policy lever to move the needle on meaningful health information exchange. The AAFP has longed called for CMS to move away from health IT utilization measures. The AAFP also opposed the revised SAFER Guides measure as it is burdensome and does not advance programmatic goals or foster improvement.
CMS will maintain a performance threshold of 75 points for the 2024 performance year instead of finalizing the proposal to increase it to 82 points.	Positive	The AAFP expressed concerns about defining the prior period as three performance periods based on existing data that is not an accurate representation of performance within the program and could set a perilously high threshold that would negatively impact the healthcare system.
CMS finalized the proposal to revise the targeted review timeframe to begin on the day final scores are made available and end 30 days after publication of payment adjustments. CMS also finalized its proposal to require practices to provide additional information to CMS within 15 days of the request.	Negative	The AAFP encouraged CMS to review its processes and identify potential operational efficiencies that would allow more flexibility in this timeline.
CMS is not finalizing its proposal to make qualifying participant determinations at the individual level.	Positive	The AAFP opposed this proposal and advocated for CMS to make determinations at both the individual and alternative payment model (APM) entity level and use whichever determination was most advantageous to the eligible clinician.

CMS is finalizing its proposal to update the definition of CEHRT for Advanced APMs (AAPMs). CMS is delaying its proposal to increase the 75% threshold for CEHRT use until the 2025 performance year.	Positive	The AAFP believes the current 75% threshold is adequate and is concerned that increasing the threshold will increase administrative burden and diminish the additional flexibilities afforded to AAPM participants.
CMS finalized updates to the quality measure inventory. CMS finalized the addition of the Preventive Care and Wellness Composite Measure. CMS also finalized the removal of individual measures included in the composite (Breast Cancer Screening, Colorectal Cancer Screening, Tobacco Use Screening and Cessation Intervention, and Screening for High Blood Pressure and Follow-up Documentation.	Negative	The AAFP opposed the inclusion of the Preventive Care and Wellness composite and the removal of the individual component measures.