Summary of the CY 2024 Medicare Physician Fee Schedule Proposed Rule

On July 13, 2023, the Centers for Medicare & Medicaid Services (CMS) released the CY 2023 Medicare Physician Fee Schedule (MPFS) proposed rule. This regulation also impacts the Quality Payment Program (QPP). CMS also released accompanying fact sheets on the MPFS and Medicare Shared Savings Program proposals. Comments on the proposed rule are due by September 11, 2023. The AAFP will thoroughly review the proposed rule and provide comments to CMS. The final rule will be released around November 1, 2023, and will take effect on January 1, 2024, except where specified otherwise in the final rule.

2024 Conversion Factor and Overall Impact on Family Medicine

CMS proposes to decrease the conversion factor (i.e., the amount Medicare pays per relative value unit (RVU)) to $32.75, a decrease of $1.14, or 3.34%, from CY 2023. This is due to partially expiring conversion factor relief enacted by Congress and budget neutrality adjustments. When considering expiring conversion factor relief, the AAFP estimates the impact will be a 1.75% increase in total allowed charges for family physicians. CMS estimates about a 1% additional increase in allowed charges for those in the "non-facility" setting, which is generally positive for primary care. CMS estimates that, in the absence of any change to the conversion factor, RVU changes and other policies included in the proposed would yield a 3% increase in Medicare allowed charges for family physicians.

Most of the potential gain in allowed charges for family medicine can be attributed to CMS moving forward with the implementation of an add-on code (G2211) for office visits. This is a significant win for primary care, and one for which the AAFP has strongly advocated. CMS noted in its press release on the proposed rule "Primary care is instrumental in the delivery of high-quality, whole-person care. CMS is recognizing the value and inherent complexity in primary and longitudinal care by proposing to implement new payment and coding to accurately and appropriately pay for these services, which aligns with the goals articulated in the HHS Initiative to Strengthen Primary Care."

Determination of Practice Expense RVUs

Given the American Medical Association's (AMA's) intended data collection efforts in the near future and because methodological and data source changes to the Medicare Economic Index (MEI) finalized in 2023 would have significant impacts on physician fee schedule (PFS) payments, CMS believes delaying implementation of the finalized 2017-based MEI cost weights for the RVUs is consistent with its efforts to balance payment stability and predictability with incorporating new data through more routine updates. Therefore, CMS is not proposing to incorporate the 2017-based MEI in PFS rate setting for CY 2024. CMS is likewise not proposing any changes in the MEI itself.

CMS's proposed clinical labor pricing for CY 2024 is based on the clinical labor pricing CMS finalized in the CY 2023 PFS final rule, incremented an additional step for Year 3 (2024) of the

four-year transition, which will be complete in 2025. CMS proposes some technical corrections and refinements to specific direct practice expense inputs for select codes.

Lastly, CMS solicits public comment on strategies for updates to practice expense data collection and methodology. As it prepares to receive information from the current AMA Physician Practice Information Survey (PPIS), CMS seeks comments from interested parties on strategies to incorporate information that could address known challenges CMS experienced in implementing the initial AMA PPIS data. CMS also seeks to understand whether, upon completion of the AMA's updated PPIS data collection effort, contingencies or alternatives may be necessary and available to address lack of data availability or response rates for a given specialty, set of specialties, or specific service suppliers who are paid under the PFS.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act

CMS received several requests to add services to the telehealth list. However, none of the requests met the criteria to be added to the list on either a Category 1 or Category 2 basis. Instead, CMS will keep the codes on the telehealth services list through CY 2024, after which CMS will either remove the codes from the list or re-evaluate their status for CY 2025. Examples include Hospital Care Services (Current Procedural Terminology (CPT) codes 99221-99223), Emergency Department Services (CPT codes 99281-99283), Hospital Inpatient Services (CPT codes 99234-99236 and 99238-99238), and health and well-being coaching (CPT codes 0591T-0593T). CMS proposes to add Healthcare Common Procedure Coding System (HCPCS) code GXXX5 (administration of a standardized, evidence based SDOH assessment tool, 5-15 minutes) on a permanent basis.

CMS proposes to implement several provisions of the *Consolidated Appropriations Act of 2023* (CAA), including:

- Delaying the in-person requirements for telehealth services for the purposes of diagnosis, evaluation, or treatment of a mental health disorder until January 1, 2025
- Removing originating site restrictions though CY 2024
- Maintaining the expanded list of telehealth practitioners through CY 2024
- Recognizing marriage and family therapists and mental health counselors as telehealth practitioners, effective January 1, 2024
- Extending coverage of audio-only services on the Telehealth Services List as of December 29, 2022, through CY 2024. (CMS notes the telephone E/M services (CPT codes 99441-99443) will remain active and priced through CY 2024.)

CMS proposes to pay telehealth services reported with place of service (POS) 10 (telehealth provided in patient's home) at the non-facility rate and services reported with POS 02 (telehealth provided other than in patient's home) at the facility rate.

CMS proposes to remove telehealth frequency limitations for inpatient and nursing facility services and critical care consultation services through CY 2024.

CMS proposes to define direct supervision to permit the presence and immediate availability of the supervising practitioner through real-time audio and video interactive communications through December 31, 2024. CMS seeks comment on whether they should extend this definition beyond 2024. CMS also proposes to allow teaching physicians in all teaching settings to have a

virtual presence for services furnished virtually (e.g., three-way telehealth visits, with all parties in separate locations).

Evaluation and Management (E/M) Visits

CMS proposes to make its add-on code, G2211, for office/outpatient E/M complexity separately payable with dates of service on or after January 1, 2024. CMS also proposes several policy refinements with respect to code G2211. For instance, CMS proposes that code G2211 would not be payable when the office/outpatient E/M visit is reported with payment modifier-25.

Further, CMS proposes to change its utilization assumptions related to code G2211. CMS had previously assumed code G2211 would be reported with 90% of all office/outpatient E/M services. Now, CMS proposes to assume it will only be reported with 38% of all office/outpatient E/M visits initially and 54% of all office/outpatient E/M visits when fully adopted. These lower utilization assumptions will have positive impacts on the resulting budget-neutrality calculations.

CMS seeks public comment about the potential range of approaches it could take to improve the accuracy of valuing services. CMS is especially interested in how it might improve the accuracy of valuation for services and seeks information about how it might evaluate E/M services with greater specificity, more regularly and comprehensively. CMS is interested in ways it could potentially improve processes and methodologies and requests specific recommendations on ways it can improve data collection and make better evidence-based and more accurate payments for E/M and other services while ensuring data collection from, and documentation requirements for, physician practices are as least burdensome as possible. Finally, CMS is interested in whether commenters believe the current AMA Relative Value Scale Update Committee is the entity best positioned to provide -recommendations to CMS on resource inputs for work and practice expense valuations, as well as how to establish values for E/M and other physicians' services; or if another independent entity would better serve CMS and interested parties in providing these recommendations.

CMS proposes to further delay the implementation of its new definition of the "substantive portion" of split (or "shared") facility visits (i.e., more than half of the total time) through at least December 31, 2024. CMS proposes to maintain the current definition of "substantive portion" for CY 2024; the current definition allows for use of either one of the three key components (history, exam, or MDM) or more than half of the total time spent to determine who bills the visit.

Geographic Practice Cost Indices (GPCIs)

The CY 2024 work GPCIs and summarized geographic adjustment factors in the proposed rule do not reflect the 1.0 work floor, which is set to expire at the end of CY 2023, unless Congress intervenes. Payment localities that have a 1.0 work GPCI floor will likely experience a reduction in Medicare payment for services when the floor expires, all other things being equal.

Advancing Access to Behavioral Health

CMS proposes an increase in the valuation for timed behavioral health services under the PFS. Specifically, CMS proposes to increase the work RVUs for General Behavioral Health Integration Care Management (CPT code 99484) from 0.61 to 0.93.

As required by the in the CAA, CMS proposes to establish new HCPCS G-codes (GPFC1 and GPFC2) for crisis services furnished in any non-facility place of service other than the

physician's office setting. CMS proposes to use the existing definition of the term "home" for implementation of these codes to broadly include temporary lodging, such as hotels and homeless shelters, and other sites near the home used by the patient for privacy during mental health visits.

CMS proposes to include Marriage and Family Therapists (MFTs), mental health councilors (MHCs), and addiction councilors who meet the same qualifications as MHCs to bill for Medicare services, as required by the CAA. CMS will update behavioral health integration codes to allow for billing by MFTs and MHCs.

CMS also proposes to allow opioid treatment programs to continue allowing audio-only visits for periodic assessments through the end of CY 2024 to minimize interruptions to care because of changes at the end of the COVID-19 public health emergency.

Medicare Shared Savings Program (MSSP)

CMS proposes to make several changes refining MSSP policies. These proposed changes are directionally consistent with the AAFP's advocacy to improve value-based care participation opportunities for family physicians, particularly those caring for rural and other underserved populations.

To address concerns related to the revised quality reporting requirements for MSSP accountable care organizations (ACOs), CMS proposes to establish a new collection type for ACOs called "Medicare Clinical Quality Measure for ACOs Participating in the MSSP (Medicare CQM)." Medicare CQMs would allow ACOs to report on only their attributed beneficiaries who meet the definition of a "beneficiary eligible for Medicare CQM(s)" instead of all payers. CMS plans to provide ACOs with a list of beneficiaries who are eligible for Medicare CQMs at the beginning of the quality data submission period. ACOs will continue to have the option to report eCQMs/Merit-based Incentive Payment System (MIPS) CQMs with all payer/all patient data. Additionally, 2024 will be the final year ACOs may report using the CMS Web Interface. CMS intends for Medicare CQMs to serve as a transition collection type, and their goal is for ACOs to report on all payer/all patient data in the future.

CMS also proposes to sunset the MSSP certified electronic health record technology (CEHRT) threshold requirements and instead require all MIPS eligible clinicians (ECs), Qualifying Alternative Payment Model Participants (QPs), and Partial QPs participating in the ACO satisfy the MIPS promoting interoperability performance category measures and requirements.

CMS seeks comments on their overall approach to align the quality measures in the Adult Universal Foundation with measures used in the MSSP. CMS also seeks feedback on ways to encourage specialists to report MIPS Value Pathways in the MSSP.

Advanced payments

In the 2023 PFS final rule, CMS finalized a new payment option to make Advance Investment Payments (AIPs) to ACOs that are low revenue, inexperienced with performance-based risk Medicare ACO initiatives, new to the MSSP, and serve underserved populations beginning January 1, 2024. CMS proposes a series of technical modifications to refine AIP policies for ACOs entering agreement periods on January 1, 2024, including:

- In the 2023 PFS final rule, CMS finalized an ACO receiving AIPs must remain in a one-sided model for the duration of its agreement period in which it receives AIPS. Moving to two-sided risk before the agreement period ended would result in the ACO having to repay all the AIPs within 90 days of receiving written notice from CMS. CMS proposes modifying the AIP eligibility requirements to allow an ACO to advance to a two-sided model in the BASIC track beginning with the third performance year in which the ACO receives AIPs.
- CMS proposes to modify the termination policies to explicitly state CMS would immediately terminate AIPs to an ACO for future quarters if an ACO voluntarily terminates from the MSSP.
- CMS proposes to allow ACOs to seek review of quarterly AIP payment calculations.

Beneficiary Assignment

CMS proses modifications to the assignment methodology, the definition of an assignable beneficiary, and the definition of primary care services used for assignment to increase access and result in a greater number of beneficiaries assigned to ACOs, particularly from underserved populations, which have been less likely to be assigned to ACOs in the past. CMS proposes an expanded window for assignment from 12-months to 24-months. 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 proposed expanded 24-month window for assignment.

CMS also proposes to revise the definition of primary care services used for assignment in the MSSP regulations to include Smoking and Tobacco-use Cessation Counseling; Remote Physiologic Monitoring; Cervical or Vaginal Cancer Screening; Office-Based Opioid Use Disorder Services; Complex Evaluation and Management Services; Community Health Integration services; Principal Illness Navigation services; Social Determinants of Health (SDOH) Risk Assessment; Caregiver Behavior Management Training; and Caregiver Training Services.

Benchmarking and Risk Adjustment

When the CMS-Hierarchical Condition Category (HCC) risk adjustment model changes, the MSSP performance year and benchmark year comparisons are calculated using different CMS-HCC risk adjustment models under the current MSSP risk adjustment methodology. CMS proposes applying the same CMS-HCC risk adjustment model used in the performance year for all benchmark years when calculating prospective HCC risk scores for agreement periods beginning on January 1, 2024, and in subsequent years. This approach is the same three-year phase-in as Medicare Advantage to the revised 2024 CMS-HCC model.

CMS seeks comment on potential future developments of MSSP policies, including incorporating a higher risk track than the ENHANCED track and policies to promote ACO and community-based organization collaboration.

Medicare Part B Payment for Preventive Vaccine Administration Services

CMS proposes to renew and extend the additional payment for at-home COVID-19 vaccination to other Part B-covered vaccines (pneumococcal, influenza, and hepatitis B). Under this proposal, the in-home additional payment is limited to once per visit even if multiple vaccines are administered, but a distinct administration payment will still be provided for each vaccine administered. Vaccine payment will continue to be annually updated based upon the MEI percentage increase and adjusted to reflect geographic cost variation.

Appropriate Use Criteria for Advanced Diagnostic Imaging

CMS proposes to pause implementation of the Medicare appropriate use criteria (AUC) program for re-evaluation and rescind the current AUC program regulations. CMS does not propose a timeframe for restarting implementation efforts, citing data integrity and accuracy risks and patient access issues. CMS believes the real-time claims-based reporting requirement is an overwhelming barrier to the AUC program becoming wholly operational. CMS also acknowledges that fully implementing the penalty phase of the AUC program in its current form would likely result in inappropriate claims denials. CMS will continue efforts to find a workable implementation approach for the program.

Expand Diabetes Screening and Diabetes Definitions

CMS proposes adding the Hemoglobin A1C test (HbA1c) to the list of covered diabetes screening tests and streamlining testing coverage limits so all beneficiaries, regardless of their diagnostic status, may receive up to two diabetes screening tests per year.

To allow for evolving clinical standards for diagnosis, CMS proposes simplifying the regulatory definition of diabetes to “diabetes mellitus, a condition of abnormal glucose metabolism.”

Requirement for Electronic Prescribing for Controlled Substances (EPCS) for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan (section 2003 of the SUPPORT Act)

CMS proposes to maintain its policy of not financially penalizing clinicians who fail to meet the mandated 70% threshold for electronically prescribing controlled substances under Medicare Part D. CMS will continue issuing notices of noncompliance, with no date given for imposing future financial penalties.

CMS proposes to remove the “same entity exception” finalized in the CY 2022 PFS final rule, which currently applies to prescriptions where the prescriber and dispensing pharmacy are employed by the same entity. CMS notes that prescription drug event data used to evaluate prescriber compliance with the CMS EPCS Program cannot consistently identify when prescribers and dispensing pharmacies are part of the same entity, rendering the exception pointless. CMS also proposes to expand the available standards for same legal entities by adopting language that would allow either HL7 messages or the NCPDP SCRIPT Standard to be used when all actors in an electronic prescribing transaction are employed by the same entity. This would expand the standards prescribers could use and align program requirements with Medicare’s E-Prescribing and Prescription Drug Program final rule.

CMS proposes to define how the CMS EPCS Program’s compliance threshold calculation will be impacted by prescriptions with multiple fills, suggesting renewals—but not refills—would

count as an additional prescription in a given measurement year. CMS believes there would be a significant burden increase for small prescribers if every fill were to be included, with many at risk of no longer qualifying for the small prescriber exception.

CMS proposes to modify the “recognized emergency” and “extraordinary circumstances waiver” exceptions definitions, which would allow prescribers more flexibility in requesting an extraordinary circumstances waiver and would instruct CMS to identify which events trigger the recognized emergency exception. CMS also intends to align the program’s determination of an emergency exception with the MIPS automatic extreme and uncontrollable circumstances policy. CMS proposes that any prescriber impacted by a recognized emergency exception would be excepted for the whole measurement year, not the length of the emergency. If a prescriber continued to experience exceptional circumstances beyond the measurement year, the prescriber would need to submit a new waiver application. CMS proposes to give prescribers 60 days from the date of an issued notice of non-compliance with the program to request a waiver.

Social Determinants of Health Risk Assessment in the Annual Wellness Visit

CMS proposes adding an optional SDOH risk assessment to the Annual Wellness Visit (AWV). To be eligible for an additional payment, providers must deliver the SDOH Risk Assessment on the same day as the AWV using a standardized, evidence-based tool that aligns with the beneficiary’s educational, developmental, and health literacy needs, while also being culturally and linguistically appropriate. CMS will not mandate the use of any specific tool but provides suggested examples. CMS proposes to establish a stand-alone G-code (GXXX5) for SDOH Risk Assessment furnished in conjunction with an E/M visit. This code would also be used to report SDOH Risk Assessment in conjunction with the Medicare AWV.

This proposal is related CMS’ proposal to create of G-codes for services addressing social determinants of health, including codes to provide Community Health Integration (CHI) services. CMS proposes payment for social workers, Community Health Workers (CHWs), and other staff who furnish CHI services that address SDOH needs identified during an E/M visit or AWV.

In this proposal, CHI personnel must be certified or trained to deliver CHI services, which would be performed incident to the billing practitioner and limited to twelve visits per year. Alternatively, CMS proposes a practitioner may arrange for CHI services through an externally contracted organization, such as a community-based organization that employs CHWs (assuming there is clinical integration between both parties). CMS seeks additional comment and information on how CHI services are typically delivered, including the frequency, time, and location of services, in addition to required training for CHI personnel.

CMS also proposes a code for the payment of Principal Illness Navigation (PIN) services, which may be initiated upon an E/M visit to address a serious condition that places the patient at high-risk for hospitalization, acute decompensation, or other serious decline and requires frequent monitoring and adjustment of a disease plan or treatment regiment, or assistance from a caregiver. CMS describes PIN services as like the proposed CHI services, but provided to beneficiaries who may not have SDOH needs, or with needs that are specific to their disease or condition.

Updates to the Quality Payment Program

MIPS
In the quality performance category, CMS proposes to maintain the data completeness threshold of 75% for the 2026 performance year. CMS proposes to increase the threshold to 80% for the 2027 performance year. CMS proposes updates to the quality measure inventory and will include a total of 200 measures. CMS proposes to require groups, virtual groups, and alternative payment model (APM) entities to contract with a CMS-approved vendor that would administer the Consumer Assessment of Healthcare Providers and Systems for MIPS in Spanish to Spanish-preferring patients, in addition to English.

CMS proposes five new episode-based cost measures: depression, emergency medicine, heart failure, low back pain, and psychoses related conditions. CMS proposes to remove the Simple Pneumonia with Hospitalization cost measure. CMS identified issues with its previously finalized methodology to calculate improvement scoring for the cost performance category, so CMS proposes modifications to its methodology to address these issues, including calculating each MIPS EC's cost improvement score at the category level. The maximum improvement score will be one percentage point. CMS proposes to implement this change with the 2023 performance period.

CMS proposes to increase the performance period for the promoting interoperability performance category from 90 continuous days to 180 continuous days. They also propose to modify the definition of CEHRT to no longer reflect year-specific editions and to incorporate changes made by the Office of the National Coordinator to the definition of Base EHR and its certification criteria for health information technology. Additionally, CMS proposes to amend the Safety Assurance Factors for Electronic Health Records Resilience (SAFER) Guide measure and require ECs attest "yes" to completing the self-assessment of their implementation safety practices. Currently, ECs must attest "yes" or "no" to completing the self-assessment to satisfy the measure. Beginning in 2024, if an EC attests "no" to the measure, they will receive zero points for the promoting interoperability category.

CMS proposes to increase the performance threshold to 82 points for the 2024 performance year. Relatedly, CMS proposes to modify how they define the "prior period" used to determine the performance threshold. Rather than using a single performance year, CMS believes the statute provides flexibility to use multiple performance periods. Therefore, CMS proposes to establish the performance threshold using final scores from a span of three performance periods. The threshold for 2024 is based on performance years 2017-2019. The statutory maximum payment adjustment for 2024 is ±9 percent.

MIPS Value Pathways (MVPs)
CMS proposes five new MVPs for the 2024 performance year: Women's Health, Infectious Disease (Hep C and HIV), Mental Health and Substance Use Disorder, Quality Care for Ear, Nose, and Throat, and Rehabilitative Support for Musculoskeletal Care. CMS is consolidating the Promoting Wellness and Optimizing Chronic Disease Management into a single MVP titled Value in Primary Care.

Advanced Alternative Payment Models (AAPMs)
CMS proposes to make QP determinations at the individual EC level only. CMS' current policy primarily makes QP determinations at the APM entity level. CMS proposes to increase the QP and Partial QP thresholds. Under the Medicare option, an EC must receive at least 75% of their

Medicare payments or see 50% of their Medicare patients through the AAPM to be considered a QP. The Partial QP thresholds are 50% of payments and 35% of patients. The thresholds are the same under the All-Payer Combination Option. However, the EC must meet the Medicare minimums of 25% of payments or 20% of patients (20% and 10% for Partial QP status). CMS notes that the CAA only extended the AAPM bonus for one year. As such, there is no AAPM bonus for the 2024 performance year/2026 payment year. Beginning with the 2026 payment year, QPs will receive a 0.75% update to their conversion factor, while MIPS ECs will receive a 0.25% update.