

## **CY 2024 Medicare Physician Payment Schedule and Quality Payment Program (QPP) Final Rule Summary**

On November 2, 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 [final rule](#). The rule includes finalized proposals related to Medicare physician payment and the Quality Payment Program (QPP). These policies will take effect on January 1, 2024, unless otherwise noted. In September, the American Medical Association (AMA) submitted a comprehensive [comment letter](#) in response to the proposed rule and recommended constructive steps that CMS could take to ensure the 2024 Medicare physician payment system reduced the negative financial impact on physicians and protected patient access to care. This final rule encompasses several crucial provisions that could significantly impact Medicare physician payment and the QPP. Key finalized proposals from the rule include:

1. **Reduction in Medicare Conversion Factor:** The final rule includes a 3.37 percent reduction in the 2024 Medicare conversion factor, lowering it from \$33.8872 to \$32.7442. Additionally, the anesthesia conversion factor is finalized to be reduced from \$21.1249 to \$20.4349.
2. **Budget Neutrality Cuts from the Evaluation and Management (E/M) Add-on Code:** Despite comments from the AMA and others that the code is ambiguous and there is uncertainty about when to report it, CMS did not further reduce the utilization estimate or associated budget neutrality impact of the new E/M add-on code, G2211, which was finalized in 2021 but then delayed for three years by Congress. Specifically, CMS maintained its estimate from the proposed rule that the add-on code will be reported with 38 percent of office visits in 2024.
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. **Maintained Performance Threshold in the Merit-based Incentive Payment System (MIPS):** In response to AMA advocacy, CMS maintained the performance threshold to avoid a penalty in MIPS at 75 points in 2024. As a result, 78 percent of eligible clinicians are expected to avoid a MIPS penalty in 2026, a significant improvement from the CMS projection that just over half of eligible clinicians would avoid a penalty in the proposed rule.
5. **Delay of Mandatory Electronic Clinical Quality Measure (eCQM) Adoption:** CMS finalized its proposal 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. They also finalized their proposal to establish a new collection tool for ACOs-only to submit quality measures. The tool, known as Medicare Clinical Quality Measures (Medicare CQMs), is a response due to the challenges ACOs face with reporting on all-payer data.

## Payment Provisions

### Conversion Factor and Specialty Impact

The 2024 Medicare conversion factor will be reduced by 3.37 percent from \$33.8872 to \$32.7442. Similarly, the anesthesia conversion factor will be reduced from \$21.1249 to \$20.4349. 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 4.6 percent MEI increase for 2024. Physician practices cannot continue to absorb these increasing costs while their payment rates dwindle. **We urge all physicians to tell Congress to cancel the cuts and preserve access to care for Medicare beneficiaries.**

The AMA will develop and share 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.

### Relative Values – RUC Recommendations

CMS accepted and is implementing 97 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.

In the RUC's efforts to ensure gender equity in valuation, the RUC identified that the additional resources required to provide a pelvic exam during an E/M service should be recognized and, therefore, referred the issue to the CPT Editorial Panel. The Panel created a new CPT code, and the RUC reviewed the new service and submitted its recommendation to CMS. CMS accepted the recommendation as proposed — the new pelvic exam CPT code will be implemented on January 1, 2024.

In the CY 2021 MFS Final Rule, CMS implemented the RUC recommendation to revalue the bundled CPT codes used to report delivery, antepartum, and postpartum maternity care services to account for increases in the values of office/outpatient E/M services. For CY 2024, CMS accepted the RUC recommendation to increase maternity services to incorporate increases to the hospital 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 four 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 comments identifying potentially misvalued services for review. CMS reviewed each of these comments and concluded that the work and practice expense be reviewed for CPT code 59200 *Insertion of cervical dilator (eg, laminaria, prostaglandin) (separate procedure)* and the practice expense be reviewed for therapeutic apheresis and photopheresis CPT codes 36514, 36516 and 36522. The RUC will review these codes in January 2024. Additionally, CMS 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.

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#### **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 finalized its proposal 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 clarified that it will not allow payment for G2211 when reported on the same date as an E/M visit reported with modifier -25.

CMS requested 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. CMS recognized that the RUC, AMA, and other commenters provided 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 revised its definition of “substantive portion” of a split (or shared) visit to reflect the revisions to the Current Procedural Terminology (CPT) E/M guidelines. Specifically, for 2024, for purposes of Medicare billing for split (or shared) services, the definition of “substantive portion” means more than half of the total time spent by the physician and qualified health professional (QHP) performing the split (or shared) visit, or a substantive part of the medical decision making as defined by CPT. A split or shared visit refers to an E/M visit performed by both a physician and a 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. 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.

#### **MEI and the PPI Survey**

In last year’s final rule, CMS finalized updated MEI weights for the different cost components of the MEI for CY 2023. However, CMS also noted that they postponed implementation of the MEI changes until time uncertain, referencing the need for continued public comment due to the significant impact to physician payments. If the implementation of the MEI weights was budget neutral, overall physician work payment would be cut by 7 percent and professional liability insurance (PLI) payment would be reduced severalfold. These large shifts are principally due to a substantial error in CMS’ analysis of the US Census Bureau’s Service Annual Survey (SAS), which omitted nearly 200,000 facility-based physicians. After correcting for this major omission, the physician work MEI weight would instead increase and PLI would experience a much smaller reduction.

In the CY 2024 final rule, instead of correcting the flaw pointed out by the AMA, CMS only acknowledged the flaw and incorrectly stated that there is currently no mechanism for identifying expenses for facility-based physicians. CMS also reiterated it will continue to postpone implementation of the updated MEI weights,

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referencing the AMA's national study to collect representative data on physician practice expenses, the AMA Physician Practice Information (PPI) Survey.

The PPI Survey, supported by more than 170 health care 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 health care 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, including from their own homes without having to go to a clinic or other medical facility to receive telehealth from a distant site. Also, 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 also establishing policy 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 services; 2) lift the frequency limits on telehealth visits for subsequent inpatient hospital and skilled nursing facility visits; and 3) allow direct supervision to be provided virtually. In addition, consistent with AMA advocacy, physicians providing telehealth services from locations that are not their primary practice location, such as their home, will not be required to report their home address on their Medicare enrollment. Finalized policies on virtual supervision of residents are discussed below.

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

CMS has finalized the post-COVID-19 public health emergency (PHE) Medicare payment policies for the CPT codes for RPM and RTM. The final rule clarifies that: RPM services can only be provided to established patients; codes describing monthly monitoring can be reported only if a minimum of 16 days of data have been collected, but the treatment management codes are not included in this limitation; and 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 of whether 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.

### **Supervision of Residents in Teaching Settings**

In the 2021 MFS final rule, CMS established that after the end of the PHE, teaching physicians may meet the requirements to be present for the key or critical portions of services involving residents through a virtual presence, but only for services furnished in residency training sites outside an OMB-defined metropolitan statistical area (MSA). Within an MSA, for payment under the MFS, CMS finalized that teaching hospitals must have a physical presence during the key portion of the service provided by residents.

Again, given concerns about abrupt transitions to pre-PHE policies and in alignment with the telehealth policies extended under the CAA 2023, CMS proposed to allow the teaching physician to have a virtual presence in all teaching settings when the service is furnished virtually (e.g., a three-way telehealth visit, with all parties in separate locations) through 2024. CMS finalized this proposal, and it will continue exercising enforcement discretion to this policy through 2024.

In the proposed rule, CMS also sought comments and information about how telehealth services can be furnished in all residency training locations beyond 2024, including what clinical treatment situations are appropriate for the virtual presence of the teaching physician. CMS anticipates considering various types of teaching physician services, when it is appropriate for the teaching physician and resident to be co-located, and how virtual presence could support patient safety, particularly at-risk patients. CMS also invites data or other information on these issues.

In response to a comment, CMS clarifies that the policy continues to permit MFS payment when the teaching physician is present virtually only when the service is furnished virtually. In the example provided by a commenter, where the service is furnished with the resident in person at the same location with the patient and only the teaching physician is present virtually through real-time audio/video communications technology, the teaching physician is required to have a physical presence with the resident, unless the residency training location is outside an MSA. CMS acknowledges the comments it received in response to its solicitation and will consider these in future rulemaking.

CMS finalized its policy to allow teaching physicians to have a virtual presence in all teaching settings, only in clinical instances when the service is furnished virtually for all residency training locations through December 31, 2024. As finalized in the 2021 MFS final rule (84577- 84581), the required physical presence of a teaching physician in order to bill under the MFS for their services at a residency training site that is located outside of a MSA, can be met through interactive, audio/video real-time communications technology, and does not include audio-only technology.

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

CMS finalized its proposal 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. CHI is covered and paid under the Medicare program when there are SDOH needs that are interfering with the billing clinician's diagnosis and treatment of the patient. Principal Illness Navigation services are to help people with Medicare who are diagnosed with high-risk conditions (e.g., dementia, HIV/AIDS, and cancer) identify and connect with appropriate clinical and support resources. Like care management services, CHI and PHI would be initiated with an E/M or qualifying visit and performed incident to the billing physician's or practitioner's professional services. These services may be furnished under general supervision of the billing physician.

CMS finalized 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. In response to comments from the AMA, CMS did not finalize the requirement that the SDOH risk assessment must be performed on the same date as the associated E/M or behavioral health visit.

### **Geographic Practice Cost Indices (GPCIs)**

For 2024, CMS did not make any changes to the GPCIs; however, legislation that established 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.

### **Skin Substitutes**

CMS sought comments about how best to establish appropriate payment for skin substitute products under the MFS. In response, the AMA reiterated our long-standing position that CMS should separately identify and pay for

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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. CMS will consider the suggestions and concerns raised in future rulemaking.

### **Additional Payment for In-Home Preventive Vaccine Administration Services**

CMS finalized its proposal 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 CY 2024 national in-home additional payment for Part B preventive vaccine administration is \$38.55, which is geographically adjusted. The payment is annually updated by MEI.

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.

### **Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Program**

In response to concerns raised by the AMA, CMS finalized its proposal 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 ending the educational and operations testing period. Beginning Jan. 1, 2024, physicians should no longer include AUC consultation information on Medicare claims. Additionally, CMS will no longer qualify provider-led entities or clinical-decision support mechanisms and will remove this information from the AUC website. The claims processing instructions and guidance for the educational and operations testing period will also be removed.

CMS acknowledged that many of the goals of the AUC program have been met by the QPP and other value-based care initiatives, including the Medicare Shared Savings Program, advances in 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 did not finalize its proposal to include misdemeanor convictions as a reason to revoke a Medicare provider's or supplier's enrollment. It also, notably, removed the "misdemeanor conviction" language from all enrollment proposals that were finalized in the provider enrollment section. The AMA and other physician groups opposed this proposal due to concerns that this proposal could negatively impact the enrollment status of physicians with misdemeanor convictions for violating State laws restricting gender affirming care or abortions. CMS finalized its proposal that it could revoke enrollment if the provider or supplier, or any owner, managing employee or organization, officer, or director thereof, has had a civil judgment under the False Claims Act (FCA)--not including settlement agreements--imposed against them within the previous 10 years. CMS noted that it would

take into account the particular circumstances of an individual FCA judgement before taking this action and that this policy would only be applied prospectively to judgments occurring on or after the effective date of the final rule. The AMA opposed this proposal in our comment letter. The AMA also does not support CMS decision to finalize its proposal to change from 30 days to 15 days the amount of time a provider has to reverse a revocation due to adverse activity by one of the parties (e.g., owner, managing employee, authorized or delegated official, supervising physician). The AMA opposed this proposal in our comment letter. CMS finalized with changes its proposal to create a new enrollment status, referred to as 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. The AMA supported this proposal and is supportive of the changes to the final “stay of enrollment” policy that will allow for retroactive payments for services delivered during the stay period as long as the provider returned to compliance within the 60-day window.

### **Dental Services**

CMS finalized coverage and payment of 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, high-dose bone modifying agents, and Chimeric antigen receptor (CAR) T-Cell therapy, with some additional specifications to the latter. The agency also finalized clarifications 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, during, or immediately following treatment for head and neck cancer, whether primary or metastatic, regardless of site of origin and/or initial modality of treatment. The agency continues to seek feedback on additional dental services that should be added in the future. CMS also noted in the rule that it recently removed multi-procedure payment reductions payment indicators for dental services in the July 2023 release of the MFS RVU files and intends to provide additional guidance and education on claims processing for dental services in the future, including modifications to expand these policies to the FQHC setting.

In response to AMA advocacy, CMS clarifies 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 not be eligible. The Agency also states that intends to make future modifications to the dental services code set to better align with clinical practice and implement edits in the claims processing systems to block codes that would not likely be appropriate for Medicare reimbursement, such as procedures that are cosmetic in nature, and to ensure that dental services are billed and paid based under the applicable payment system. CMS is considering requiring modifiers on dental claims to help confirm the inextricable linkage with covered medical services, which the agency says will help to quantify dental services, better understand billing patterns, and inform whether revisions are necessary. Additionally, the agency clarifies that in order for dental services to be considered inextricable linked to other Medicare covered services, there must be documented coordination between the professionals.

### **Diabetes Services**

#### *Diabetes Screening and Definitions*

After years of AMA advocacy, CMS is finalizing proposals to cover the Hemoglobin A1C (HbA1c) test for diabetes screening purposes, which aligns with the United States Preventive Services Task Force updated recommendations and is expected to lead to more frequent and earlier screenings and more referrals to the Medicare Diabetes Prevention Program, particularly as the HbA1c test does not require fasting, unlike other screening tests. The HbA1c test would be available without patient cost sharing. CMS also finalized proposals to expand frequency limitations for diabetes screening to twice within a rolling 12-month period and to streamline the definition of diabetes by removing codified clinical test requirements, which are currently required for diabetes screening, Medical Nutrition Therapy (MNT), and Diabetes Self-Management Training (DSMT) services.

*Medicare Diabetes Prevention Program (MDPP)*

CMS finalized changes 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 will 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. As of Jan. 1, 2024, MDPP suppliers may no longer suspend MDPP services.

*Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) Services*

DSMT and MNT services may continue to be furnished via a telecommunications system to beneficiaries in their homes, though a 95 modifier must be applied. One-hour training (initial or follow up) required for insulin-dependent beneficiaries may also continue to be provided via telehealth. CMS finalized billing clarifications related to billing DSMT services on behalf of a DSMT entity, including telehealth services.

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

The AMA strongly opposes the supervision of Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) by non-physician practitioners and opposes removing the requirement that physicians supervise all PR, CR, and ICR. Moreover, the AMA opposes expanding supervision privileges to physician assistants, nurse practitioners, and clinical nurse specialists. However, CMS finalized section 51008 of the Bipartisan Budget Act of 2018.

Specifically, CMS revised §§ 410.47 (PR) and 410.49 (CR/ICR) to allow physician assistants (PA), nurse practitioners (NP) and clinical nurse specialists (CNS) to supervise PR, CR and ICR programs. CMS also added a new term, nonphysician practitioner (NPP), to §§ 410.47(a) and 410.49(a). This new term includes PAs, NPs, and CNSs as those terms are defined in section 1861(aa)(5)(A) of the Act. Moreover, the term "supervising physician" was amended at §§ 410.47(a) and 410.49(a) to "supervising practitioner" which would mean a physician or NPP. Finally, CMS amended the definition for pulmonary rehabilitation at § 410.47(a) and the definitions for cardiac rehabilitation and intensive cardiac rehabilitation (ICR) program at § 410.49(a) to specify that these are physician- or NPP-supervised programs.

CMS also amended §§ 410.47(b)(3)(ii)(A) and 410.49(b)(3)(ii) to specify that all settings must have a physician or NPP immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under the programs. Furthermore, CMS amended language at §§ 410.47(d) and 410.49(e) by specifying that these sections include supervising practitioner standards, rather than just supervising physician standards and removed the third standard in each section (§§ 410.47(d)(3) and 410.49(e)(3)) because CMS believed that specifying that a physician or NPP is licensed to practice medicine in the state where a PR/CR/ICR program is offered, or any corresponding reference to a NPP being licensed or authorized to practice, was redundant to the definition for each practitioner type in the Act.

**Advancing Access to Behavioral Health Services**

This section implemented Section 4121(a) of the Consolidated Appropriations Act (CAA), 2023. Section 4121(a) provided for Medicare coverage of, and payment for, the services of mental health care professionals who met the qualifications for marriage and family therapists (MFTs) and mental health counselors (MHCs) when billed by these professionals. In alignment with the CAA CMS made corresponding changes that it believes implements these legislative changes. As such, CMS created two new regulation sections at § 410.53 and § 410.54 to codify the coverage provisions for MFTs and MHCs, respectively.



CMS defined a marriage and family therapist at § 410.53 as an individual who:

- Possesses a master's or doctor's degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law of the State in which such individual furnishes the services defined as marriage and family therapist services.
- Has performed at least 2 years or 3,000 hours of post master's degree clinical supervised experience.
- Is licensed or certified as a marriage and family therapist by the State in which the services are performed.

CMS also defined "Marriage and family therapist services" at § 410.53(b)(1) as services furnished by a marriage and family therapist for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are furnished. 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 the requirements of this section. However, services furnished by a marriage and family therapist to an inpatient of Medicare participating hospital do not fall under the Medicare Part B benefit category for MFT services.

CMS defined a mental health counselor at § 410.54 as an individual who:

- Possesses a master's or doctor's degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, or professional counselor under the State law of the State in which such individual furnishes the services defined as mental health counselor services.
- Has performed at least 2 years or 3,000 hours of post master's degree clinical supervised experience.
- Is licensed or certified as a mental health counselor, clinical professional counselor, or professional counselor by the State in which the services are performed.

CMS also defined "mental health counselor services" at § 410.54(b)(1) as services furnished by a mental health counselor for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital), which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are furnished. These 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. However, services furnished by a mental health counselor to an inpatient of a Medicare participating hospital do not fall under the Medicare Part B benefit category for MHC services.

CMS added marriage and family therapist services and mental health counselor services to the list of included medical and other health services and added marriage and family therapists and mental health counselors, to the list of individuals or entities to whom payment is made.

CMS also amended § 410.32(a)(2) to add MFTs and MHCs to the list of practitioners who may order diagnostic tests to the extent that the MFT or MHC is legally authorized to perform the service under State law (or the State regulatory mechanism provided by State law) of the State in which such services are furnished.

CMS codified the payment amount for CSW, MFT, and MHC services at 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 also added MFTs and MHCs to the list of practitioners who are eligible to furnish Medicare telehealth services at the distant site.

CMS also allowed Addiction Counselors who meet all of the applicable requirements to be considered Mental Health Counselors and to enroll in Medicare as MHCs.

### **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 finalizing 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 extending its current policy allowing periodic assessments to be provided via audio-only communications through the end of calendar year 2024.

### **Coding and Payment for Administration of Complex Non-Chemotherapy Drugs**

CMS sought comment on policies regarding coding and payment for the administration of complex non-chemotherapy drugs paid under Medicare Part B. CMS 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 interested in future discussions with interested parties to work towards developing policies that accurately account for the costs involved in complex drug administration services.

### **Certified Electronic Health Record Technology (CEHRT)**

CMS finalized its proposals to revise the definitions of CEHRT for the Medicare Promoting Interoperability Program and for the Quality Payment Program and to follow the lead of the Office of the National Coordinator for Health IT (ONC) and refer to the criteria moving forward as the “ONC Certification Criteria for Health IT,” rather than a year-themed edition. ONC had proposed a new definition for its certification criteria in its recent [Health Data, Technology, and Interoperability: Certification Program Updates, Algorithm Transparency, and Information Sharing \(HTI-1\) Proposed Rule](#), but CMS does not believe that ONC must finalize their proposed rule for CMS to be able to finalize these changes of regulatory definitions of CEHRT. CMS is making this change so as updates to applicable health IT certification criteria are made by ONC, they will be incorporated into CEHRT definitions, without additional regulatory action required by CMS.

These changes will not impact EHR requirements in the CY 2024 EHR reporting period or the CY 2024 performance period, and therefore CMS predicts that it will have no impact on clinicians. ONC stated its belief that maintaining a single set of “ONC Certification Criteria for Health IT” would create more stability for the ONC Health IT Certification Program and for federal partners who reference this Program, as well as make it easier for developers of certified health IT to maintain their product certifications over time.

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

CMS finalized several changes that it projects will cumulatively increase participation in the program by 10 percent to 20 percent.

CMS finalized a new quality measure collection type for MSSP participants starting next year. CMS will share the list of beneficiaries eligible for Medicare CQMs quarterly. Following AMA advocacy, ACOs will continue to have the option to report quality data utilizing the CMS Web Interface measures in 2024, but this option will be sunset in 2025.

Despite strong opposition from the AMA and others, CMS finalized a new requirement that all MSSP participants, regardless of track or QP status, must begin reporting MIPS PI Category measures and earn a MIPS PI category score unless they would generally be excluded from reporting this data under MIPS. However, the agency delayed this change until 2025, along with public reporting requirements for this data.

CMS made changes to beneficiary assignment including adding a new third attribution “step” based on a plurality of primary care services received from physicians and other non-physician providers during an expanded assignment window of 24 months, with a requirement that the patient was seen by an ACO physician at least one time within that expanded assignment window. The agency expects most beneficiaries will still be assigned under Steps 1 and 2 of the methodology, but that adding this Step 3 will capture small amounts of previously unassigned beneficiaries that will generally add to an ACO’s attributed population. All beneficiary assignment changes will be effective starting in 2025.

CMS also finalized 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.

Lastly, CMS finalized several refinements to Advance Investment Payment (AIP) policies, including allowing AIP ACOs to advance to risk-bearing tracks beginning in performance year three and opt to early renew after two years and carry forth their AIP balance into their new performance contract. ACOs would 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.

### **Merit-Based Incentive payment System (MIPS)**

#### **Performance Threshold**

Due to strong AMA advocacy, CMS did not finalize its proposal to increase the performance threshold to avoid a MIPS penalty from 75 points to 82 points. CMS will maintain the performance threshold at 75 points for 2024. As a result, CMS estimates that approximately 22 percent of MIPS eligible clinicians would receive a negative payment adjustment for the CY 2024 performance period/2026 MIPS payment year by maintaining the performance threshold at 75 points. Under the original proposal of establishing the performance threshold at 82 points, CMS estimated that approximately 46 percent of MIPS eligible clinicians would receive a negative payment adjustment of up to –9 percent. 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 continue to advocate for wholesale changes to the MIPS program. [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 finalized five new MVPs for the 2024 performance year, along with revisions to the previously finalized MVPs. Specifically, CMS finalized its proposal to consolidate the previously finalized MVPs, Promoting Wellness MVP and Optimizing Chronic Disease Management MVP into a single primary care MVP.

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

### Quality Performance Category

CMS finalized policy changes to the quality measure inventory list which will bring the total number of quality measures to 198 for the 2024 performance period. Importantly, this figure does not encompass QCDR measures, as they are approved independently from the rulemaking process.

The finalized changes include:

- The inclusion of 11 new quality measures, one of which is a composite measure. Also, among the newly introduced measures, six are of high priority, including four patient-reported outcome measures;
- The elimination of 11 quality measures from the MIPS quality measure inventory;
- The partial elimination of three 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 finalizing no changes to the previously finalized quality measure data completeness thresholds for the 2024 or 2025 performance periods and maintains them at 75 percent. However, the agency did not finalize its proposal 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 finalized its proposal 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 removed one episode-based cost measure – Simple Pneumonia with Hospitalization. CMS finalized its proposal 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 established a maximum improvement score of one percentage point beginning with the 2023 performance period.

### Improvement Activities (IA) Performance Category

CMS is finalizing changes to the improvement activities Inventory for the CY 2024 performance period by adding five new improvement activities, modifying an existing improvement activity, and removing 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 further finalized that a MIPS eligible clinician participating in an APM receives an improvement activities performance category score of at least 50 percent if the MIPS eligible clinician reports a completed improvement activity or submits data for the quality and Promoting Interoperability performance categories. 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 finalizing its proposal to require a continuous 180-day performance period for the PI performance category beginning with the CY 2024 performance period/2026 MIPS payment year. CMS argues this ensures that the MIPS PI performance category continues to align with the Medicare PI Program for eligible hospitals and critical access hospitals.

The agency believes that having additional data available from a longer performance period is beneficial to further improve this performance category, and an integral step towards promoting health information exchange. According to CMS, this increase in the performance period will provide MIPS eligible clinicians the opportunity to continuously monitor their performance, identify gaps in their reporting, and identify areas that may require their investigation and corrective action. CMS stated that its long-term goal for PI is to ensure the meaningful use of CEHRT and information exchange throughout the year, for all data, all clinicians, and all patients. In addition, this incremental increase in the number of days in the performance period is another indication of the agency's push to move towards reporting on a full years' performance.

### **Third Party Intermediaries**

#### *Health IT Vendors*

CMS finalized its proposal 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 policy, vendors that are submitting MIPS data to the agency will now have to meet the requirements of and self-nominate to become a qualified registry or QCDR. Health IT vendors can continue to facilitate data collection and support clinicians and groups in the sign in and upload and sign in and attest submission types.

### **Public Reporting of Cost Measures**

CMS finalized its proposal to modify existing policy about publicly reporting procedure utilization data on individual clinician profile pages by incorporating Medicare Advantage data on procedure volumes. CMS sought comments about publicly reporting cost measures beginning with the CY 2024 performance period/2026 MIPS payment year and plans to take the comments into consideration for future rulemaking.

### **Projected 2024 MIPS Participation and 2026 Payment Adjustments**

CMS estimates that 686,650 physicians and QHPs will be MIPS eligible in the 2024 performance period. CMS estimates that 78 percent of eligible clinicians will avoid a penalty and/or earn a bonus. This is a significant improvement from the proposed rule and a result of CMS maintaining the MIPS performance threshold at 75 points as urged by the AMA and organized medicine. CMS estimates that the median penalty in 2026 based on 2024 performance will be -1.24 percent and the maximum will be -9 percent. MIPS penalties are redistributed as bonuses to high scorers. CMS estimates that the median bonus will be 1.74 percent and the maximum will be 2.99 percent. Overall, CMS expects to redistribute \$491 million in MIPS. Under current law, MIPS eligible clinicians will receive a 0.25 percent update to the conversion factor in 2026.

### **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,

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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
<b>Performance</b>	50 (25)	40 (20)	35 (20)	25 (10)
<b>Performance</b>	75 (25)	50 (20)	50 (20)	35 (10)

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

Following AMA calls to perform more analysis on the estimated impact, CMS did not finalize a proposal to calculate QP determinations at the individual, rather than APM Entity level starting next year and will continue to make these determinations at the APM Entity level for the 2024 performance period.

CMS finalized a change that, beginning with CY 2024, CEHRT for the purposes of Advanced APMs will mean any technology that meets the Base EHR definition plus customized certification criteria for each APM based on the specific uses of CEHRT for each model. This change is in response to calls by the AMA to allow for greater flexibility in defining CEHRT, thereby reducing burden. Despite AMA opposition, CMS ended its current threshold requiring 75 percent all eligible clinicians in each participating APM Entity (or hospital) to comply, and moving forward will now require “*all*,” i.e., 100 percent of, eligible clinicians in each APM Entity (or hospital) to comply with new CEHRT requirements. However, after AMA raised serious concerns about the proposed new 100 percent threshold, CMS delayed this threshold change until 2025 to allow for a one-year transition period and added additional flexibilities in the final rule that would allow Advanced APMs to establish requirements for CEHRT use that are “reasonable expectations for Advanced APM participants” based on clinical appropriateness adding that the agency “do[es] not expect that this would occur entirely without exceptions across all possible circumstances.” CMS says that it may establish more specific criteria for exceptions in future rulemaking if warranted.

#### Helpful links:

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