Proposed 2024 Medicare Physician Payment and Quality Reporting Changes

MGMA MEMBER-EXCLUSIVE ANALYSIS

The Centers for Medicare & Medicaid Services (CMS) **released** the proposed 2024 Physician Fee Schedule (PFS) on July 13, 2023, which makes changes to both Medicare physician payment and quality reporting program policies that generally take effect Jan. 1, 2024. These policies are only proposals and could be changed in the final PFS, which is usually released on or around Nov. 1 of each year.

MGMA will submit formal comments in response to the proposed rule and share them with members in the **MGMA Washington Connection** newsletter. If you have any questions or reactions to proposed policies, please reach out to MGMA Government Affairs at **govaff@mgma.org**.

Medical Practice Executive Insights and MGMA Takeaways

CMS estimates the 2024 Medicare PFS conversion factor to be **$32.7476, a decrease of $1.14, or almost 3.36%**, from the CY 2023 PFS conversion factor of $33.8872. MGMA and other physician organizations are actively engaging with Congress to find a solution to mitigate the cuts before they go into effect in 2024.

Additional takeaways from this proposed rule include:

- Extending flexibilities to permit split/shared E/M visits to be billed based on one of three components (history, exam, or medical decision making) or time through at least 2024;
- Reimbursing telehealth services furnished to patients in their homes at the typically higher, non-facility PFS rate;
- Continuing to allow direct supervision by a supervising practitioner through real-time audio and video interaction telecommunications through 2024;
- Continuing coverage and payment of telehealth services included on the Medicare Telehealth Services List through 2024;
- Pausing implementation and rescinding the Appropriate Use Criteria program regulations;
- Increasing the performance threshold from 75 points to 82 points for all three MIPS reporting options;
- Adding five new MIPS Value Pathways related to women's health, prevention and treatment of infectious disease, quality care in mental health/substance use disorder, quality care for ear, nose, and throat, and rehabilitative support for musculoskeletal care;
- Making numerous changes to the Medicare Shared Savings Program (MSSP) such as revising the MSSP quality performance standard, modifying the program's benchmarking methodology, and determining beneficiary assignment under the MSSP; and,
- Ending the 3.5% APM Incentive Payment after the 2023 performance year/2025 payment year, and transitioning to a Qualifying APM Conversion Factor in the 2024 performance year/2026 payment year.

Physician Payment Update

CMS estimates the 2024 Medicare PFS conversion factor to be $32.7476, a decrease of $1.14, or almost 3.36%, from the CY 2023 PFS conversion factor of $33.8872. The proposed CY 2024 anesthesia conversion factor is $20.4370, a decrease in $0.69, or almost 3.3%, from the CY 2023 anesthesia conversion factor of $21.1249.

CMS is required by law to adjust the conversion factor to maintain budget neutrality when it increases or decreases relative value units (RVUs) for services paid under the fee schedule. For CY 2024, CMS states the proposed decrease to the conversion factor is a result of the statutory update of 0.00% and the adjustment necessary to account for previously increased RVUs and other budget neutrality adjustments.

Calendar Year	Conversion Factor
2020	$36.0896
2021	$34.8931
2022	$34.6062
2023	$33.8872
2024 (proposed)	$32.7476

The conversion factor, as proposed, would not appropriately address the gap between physician practice inflationary expenses and reimbursement rates. An inflation-based update is a commonsense solution. MGMA will continue to work with Congress to pass the *Strengthening Medicare for Patients and Providers Act*, which would provide an annual Medicare physician payment update tied to inflation, as measured by the Medicare Economic Index (MEI).

Calculation of CY 2024 PFS Conversion Factor		
CY 2023 Conversion Factor		33.8872
Conversion Factor without the CAA, 2023 (2.5% Increase for CY 2023)		33.0607
CY 2024 RVU Budget Neutrality Adjustment	-2.17% (0.9783)	
CY 2024 1.25 Percent Increase Provided by the CAA, 2023	1.25 percent (1.0125)	
CY 2024 Conversion Factor		**32.7476**

CY 2023 Anesthesia Conversion Factor		
CY 2023 National Average Anesthesia Conversion Factor		21.1249
Conversion Factor without the CAA, 2023 (2.5% Increase for CY 2023)		20.6097
CY 2024 RVU Budget Neutrality Adjustment	-2.17% (0.9783)	
CY 2024 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	0.11% (1.0011)	
CY 2024 1.25% Increase Provided by the CAA, 2023	1.25% (1.0125)	
CY 2024 Conversion Factor		**20.4370**

Source: Proposed 2024 Physician Fee Schedule

Geographic Practice Cost Indices (GPCIs)

Previous legislation established a 1.0 floor on the work GPCI which is set to expire at the end of 2023, meaning the GPCIs and summarized geographic adjustment factors displayed in the rule's addenda do not reflect the floor. MGMA will urge Congress to extend the 1.0 work floor to prevent reductions in Medicare payment if and when the floor expires.

Evaluation & Management (E/M) Services

ADD-ON CODE (HCPCS CODE G2211)

CMS previously finalized E/M add-on code HCPCS code 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)*). Due to its impact on the 2021 PFS conversion factor, Congress delayed the implementation of this code through 2023.

CMS proposes to implement G2211 in 2024, but readjusted its utilization assumption from 90% in the 2021 rule to 38% (initial implementation) and 54% (full adoption) in this proposed rule. CMS further clarifies when G2211 is not appropriate, such as when reported on the same date as an E/M visit reported with modifier -25. This adjustment slightly mitigates the impact the add-on code is estimated to have on the conversion factor, however, the code will still cause payment cuts due to budget neutrality requirements. MGMA will continue to urge Congress to step in and address these reimbursement cuts prior to 2024.

SPLIT/SHARED E/M

In the CY 2022 Medicare PFS, CMS finalized a new split/shared E/M policy, defining the "substantive portion" of the visit as more than half of the total practitioner time. Under this policy, a physician would be required to see the patient for more than half of the total time of a split/shared E/M visit to bill for that service. Last year, MGMA and other national healthcare organizations were successful in achieving a one-year delay of this policy.

CMS again proposes to delay the implementation of the definition of "substantial portion" for purposes of split/shared billing and to continue to permit the substantial portion of the E/M service to be defined as either history, exam, medical decision-making (MDM) or more than half of total time.

Medicare Telehealth Services

IMPLEMENTATION OF THE CONSOLIDATED APPROPRIATIONS ACT OF 2023

The Consolidated Appropriations Act of 2023 (CAA, 2023) extended many telehealth flexibilities until Dec. 31, 2024. CMS proposes to make conforming changes to implement policies related to:

- *Extending originating site and geographic location flexibilities*. Originating sites for any service on the Medicare Telehealth Services List can include any site in the United States, including an individual's home (where the beneficiary is located at the time of the telehealth service) through Dec. 31, 2024.
- *Expanding the list of qualifying providers to offer telehealth services.* Qualified occupational therapists, physical therapists, speech-language pathologists, and audiologists can continue to be included as telehealth practitioners through Dec. 31, 2024. CMS will recognize marriage and family therapists (MFT) and mental health counselors (MHC) as telehealth practitioners starting Jan. 1, 2024.
- *Temporarily allowing audio-only services for certain services.* Coverage and payment of audio-only telehealth services specified on the Medicare Telehealth Services List is extended through Dec. 31, 2024.
- *In-person requirements for mental telehealth.* The in-person requirement for telehealth services related to the diagnosis, evaluation, or treatment of a mental health disorder will become effective on Jan. 1, 2025. CMS will delay of the in-person requirements for mental telehealth visits furnished by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) until Jan. 1, 2025.
- *Continuing payment for telehealth services offered by RHCs and FQHCs using the methodology established during the public health emergency (PHE) through Dec. 31, 2024.*

TELEHEALTH REIMBURSEMENT (FACILITY VS. NON-FACILITY RATE)

CMS proposes to reimburse telehealth services billed using the POS 10 code at the higher non-facility rate through 2024, while claims billed with POS 02 code will be reimbursed at the facility rate for 2024. If finalized, this proposal will effectively allow for payment parity between in-person and telehealth visits.

FREQUENCY LIMITATIONS ON MEDICARE TELEHEALTH SUBSEQUENT CARE SERVICES IN INPATIENT AND NURSING FACILITY SETTINGS, AND CRITICAL CARE CONSULTATIONS

Certain services added to the Medicare Telehealth Services List in the past had restrictions regarding how frequently they may be furnished via telehealth, such as a limit of once every three days for subsequent inpatient visits. For the duration of 2024, CMS is proposing to remove the telehealth frequency limitations for the following codes related to inpatient and nursing settings and critical care consultations: CPT codes 99231, 99232, 99233, 99307, 99308, 99309, 99310, G0508, G0509.

Medicare Telehealth Services, Cont.

CHANGES TO THE MEDICARE TELEHEALTH SERVICE LIST

To align with changes in the CAA, 2023, CMS intends to continue reimbursement of telehealth services on the Medicare Telehealth Services List (as of March 15, 2020) until Dec. 31, 2024. CMS further proposes to add MFTs and MHCs to the permanent list of eligible telehealth providers and to allow the following codes on a temporary basis through 2024:

- Cardiovascular and Pulmonary Rehab (CPT codes 93797, 94624);
- Deep Brain Stimulation (CPT codes 95970, 95983, 95984);
- Therapy (CPT codes 97110, 97112, 97116, 97161-97164, 97530, 97750, 97763, 90901);
- Hospital Care, Emergency Department and Hospital (CPT codes 99221, 99222, 99223, 99234, 99235, 99236, 99238, 99239, 99281, 99282, 99283); and,
- Health and Well-being Coaching (CPT codes 0591T, 0592T, 0593T).

CMS is proposing to add HCPCS code GXXX5 (*administration of a standardized, evidence-based social detriments of health risk assessment tool, 5-15 minutes*) to the Medicare Telehealth Services List on a permanent basis if it is finalized. Further, the agency proposes to change and simplify its process for analyzing requests for the addition of services to the Medicare Telehealth Services List. The new process has the following steps for CMS:

1. Determine whether the service is separately payable under the PFS.
2. Determine whether the service is subject to the provisions of section 1834(m) of the Act.
3. Review the elements of the service as described by the HCPCS code and determine whether each of them is capable of being furnished using an interactive telecommunications system as defined in section 410.78(a)(3).
4. Consider whether the service elements of the requested service map to the service elements of a service on the list that has a permanent status described in previous final rulemaking.
5. Consider whether there is evidence of clinical benefit analogous to the clinical benefit of the in-person service when the patient, who is located at a telehealth originating site, receives a service furnished by a physician or practitioner located at distant site using an interactive telecommunications system.

Starting in 2024, CMS proposes to assign Category 1 and Category 2 telehealth services into a "permanent category" while services temporarily in Category 2 or Category 3 will be assigned to a "provisional" category. The current Medicare Telehealth Service List with proposed expansions can be downloaded **here**.

DIRECT SUPERVISION VIA USE OF TWO-WAY AUDIO/VIDEO COMMUNICATIONS TECHNOLOGY

CMS is concerned about the potential consequences of transitioning to its pre-PHE policy that defines direct supervision as requiring the physical presence of the supervising practitioner. The agency believes practitioners will need time to reimplement the pre-PHE approach to direct supervision without the use of audio/video technology. To ameliorate these concerns, CMS proposes to continue defining direct supervision to allow the presence and immediate availably of the supervising practitioner through real-time audio and video interactive telecommunications through Dec. 31, 2024.

Remote Physiologic Monitoring and Remote Therapeutic Monitoring Services

Following the establishment of payment code families for remote physiologic monitoring (RPM) and remote therapy monitoring (RTM), CMS is proposing guidance on the use of RPM and RTM in conjunction with other services and providing clarification for appropriate billing. Additionally, the proposed rule makes clarifications following the end of the PHE for new vs. established patients and data collection.

The proposed 2024 PFS clarifies that RPM and RTM may be billed separately, but not together with the following care management services: Chronic Care Management (CCM), Transitional Care Management (TCM), Behavioral Health Integration (BHI), Principle Care Management (PCM), and Chronic Pain Management (CPM). The proposed rule further clarifies that for patients who receive a procedure, surgery, or related service covered under a payment for a global period, the practitioner would receive payment for RTM or RPM separate from the global service payment.

The 2021 PFS final rule required RPM services to be furnished only to an established patient following the end of the PHE. This proposed rule clarifies that patients who received remote monitoring services during the PHE are considered established patients. Finally, the requirement mandating that monitoring must occur for at least 16 days over a 30-day period was reinstated following the end of the PHE. The proposed rule clarifies that data collection minimums apply to existing RPM and RTM code families for 2024.

Behavioral and Mental Health

MARRIAGE AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS

For 2024, CMS is proposing definitions for Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC), and that both MFTs and MHCs will now be able to receive payment. Payment for clinical social workers (CSW), MFT, and MHC services will be 80% of the lesser of the actual charge for the services or 75% of the amount determined for clinical psychologist services under the PFS. Addiction counselors that meet applicable requirements to be MHCs can enroll in Medicare as MHCs.

HEALTH BEHAVIOR ASSESSMENT AND INTERVENTION SERVICES

Under this proposal, Health Behavior Assessment and Intervention (HBAI) services (CPT codes 96156, 96158, 96159, 96164, 96165, 96167, 96168, and any successor codes) could be billed by CSWs, MFTs, and MHCs where previously clinical psychologists were the only providers allowed to bill for HBAI.

INCREASED VALUATION FOR TIMED BEHAVIORAL SERVICES

CMS proposes to implement an increased valuation for timed behavioral health services over four years by applying an adjustment to the work RVUs for psychotherapy codes payable under the PFS. This change is an effort to accurately value the resources required for behavioral health services.

CRISIS CODES

The rule proposes new HCPCS codes under the PFS for psychotherapy crisis services provided in non-office settings which can include homes and temporary lodging such as hotels or homeless shelters. The payment for these services would be set at 150%of the PFS amount for non-facility sites of service. The expenditures for these new HCPCS codes would not be factored into budget neutrality adjustments.

- HCPCS GPFC1 *(Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); first 60 minutes)*; and,
- HCPCS GPFC2 *(Psychotherapy for crisis furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting); each additional 30 minutes (List separately in addition to code for primary service))*.

Clinical Laboratory Fee Schedule

CMS is proposing that for the Jan. 1, 2024, through March 31, 2024, data reporting period, the corresponding data collection period will be Jan. 1, 2019, through June 30, 2019. After this period, CMS will continue data reporting every three years. The proposed rule would phase-in payment reductions; payment for clinical laboratory diagnostic tests in CY 2023 would not be reduced below the CY 2022 payment and for CY 2024 through CY 2026, payment would not be reduced more than 15% below the proceeding calendar year rate. MGMA is **urging** Congress to address payment cuts to physician laboratories before 2024.

Appropriate Use Criteria

The *Protecting Access to Medicare Act of 2014* created the appropriate use criteria (AUC) program, which requires ordering providers to consult a qualified clinical decision support mechanism (CDSM) for applicable imaging services. The AUC program never progressed past the "educational and operations testing period," meaning there were no financial penalty consequences associated with the program. In response to **concerns** voiced by MGMA and other leading healthcare organizations, CMS proposes to reevaluate and rescind the current AUC regulations, citing challenges with the claims-based reporting requirements.

Electronic Prescribing for Controlled Substances (EPCS)

In the 2022 PFS final rule, and in accordance with Section 2003 of the SUPPORT Act, CMS stated that starting in CY 2023 it would begin initial EPCS compliance actions to provide a general timeline to evaluate prescriber compliance with electronic prescribing standards. For 2024, CMS proposes to further modify the recognized emergency exception and extraordinary circumstances waiver, and align the determination of the emergency exception with the MIPS automatic extreme and uncontrollable circumstances policy. Notably, CMS proposes to continue issuing prescriber notices of non-compliance rather than financially penalizing clinicians who fail to meet the requirements.

Provider Enrollment

CMS previously finalized regulations to revoke a provider or supplier's enrollment if a supplier or a provider has been convicted of a Federal or State felony. The proposed rule adds the conviction of a misdemeanor under Federal or State law within the previous 10 years as a reason for revocation. Additionally, the proposed rule would require all Medicare providers and suppliers to report additions, deletions, or changes in their practice locations within 30 days. Finally, the proposed rule would also add a new enrollment status — "stay of enrollment" — as an interim status determined by the agency on a case-by-case basis used to delay revocation or deactivation of billing privilege for paperwork mistakes or missed deadlines for 60 days.

Occupational Therapist and Physical Therapist Supervision

Historically, CMS has required that all physical therapy (PT) and occupational therapy (OT) services be under the direct supervision of PTs and OTs in private practice. For 2024, CMS is proposing that physical therapy assistants and occupational therapy assistants in private practices be allowed to furnish RTM services when under the general supervision of the PT or OT.

Caregiver Training

CMS proposes to allow both physician and non-physician practitioners (NPP) — including physical therapists, occupational therapists, speech-language pathologists, physician assistants — to bill for providing training to caregivers of patients in certain situations, even when the patient is not present.

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

RPM AND RTM SERVICES

CMS is proposing to expand payment coverage for RPM and RTM services provided in FQHCs and RHCs by allowing them to report these services under existing general care management code, G0511. To reflect the expected increase in usage of the G0511 code, CMS is also proposing that the payment calculation methodology for this code be reviewed and updated.

SUPERVISION REQUIREMENTS FOR BEHAVIORAL HEALTH SERVICES

CMS proposes that behavioral health services furnished in a RHC or FQHC setting "incident to" a physician or NPP's services can be done under general, rather than direct supervision.

Social and Community Health Services

CMS intends to pay separately for Community Health Integration Services, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation (PIN) services. For 2024, CMS proposes to add an optional SDOH risk assessment to the Annual Wellness Visit (AWV).

In-Home Preventative Vaccine Administration Services

CMS proposes to continue paying for in-home administration of the COVID-19 vaccine (HCPCS code M0201) and extend in-home administration payment to pneumococcal, influenza, and hepatitis B vaccines. This additional in-home administration payment would be limited to one payment per home visit. CMS will continue to update the payment amount annually by the percentage increase in MEI (predicted to be 4.5% for 2024).

Medicare Shared Savings Program (MSSP)

To promote the agency's value-based care strategy of growth, alignment, and equity, CMS is proposing numerous changes to the MSSP. The 2023 final PFS included significant updates to the MSSP and this year's proposal makes further modifications in response to concerns raised by interested parties. As of Jan. 1, 2023, 10.9 million Medicare beneficiaries received care from one of 573,126 providers in the 456 Accountable Care Organizations (ACOs) participating in the MSSP.

MEDICARE CQM

The proposed rule would establish the Medicare Clinical Quality Measure for ACOs Participating in the MSSP (Medicare CQM) collection type for ACOs to report their quality measures for 2024 and beyond. ACOs participating in the MSSP would be allowed to collect and report data on the ACOs' fee-for-service (FFS) beneficiaries that meet the definition of a beneficiary eligible for Medicare CQM, instead of its all payer or all patient population. The Medicare CQM is meant to alleviate issues ACOs have experienced reporting eCQMs and MIPS CQMs, and to ease the transition to all payer/all patient MIPS CQMs and eCQMs. ACOs would still have the option to report quality data using the CMS Web Interface (2024 will be the final year), eCQMs, and/or MIPS CQMs collection types. The data completeness threshold would be 75% for the 2024-2026 performance periods, and 80% for the 2027 performance period.

CMS proposes to develop new benchmarks for scoring ACOs on the Medicare CQMs to align with MIPS benchmark policies. ACOs that report Medicare CQMs would be eligible for the health equity adjustment to their quality performance category.

ALIGNING REQUIREMENTS FOR MSSP AND MIPS

Under current policy, an ACO in a track that does not meet the standards to be an Advanced APM must certify annually that at least 50% of eligible clinicians use certified electronic health record technology (CEHRT). ACOs in a track that meets the standard to be an Advanced APM must certify annually that at least 75% of clinicians use CEHRT.CMS is proposing to remove these MSSP CEHRT threshold requirements in 2024.

APM Entities can now report the Promoting Interoperability (PI) performance category at the APM Entity level while maintaining the option to report at the individual or group level. Effective Jan. 1, 2024, CMS will require all MIPS-eligible clinicians, Qualifying Participants (QPs) and Partial QPs participating in an ACO to report the PI performance category measures and requirements to MIPS as either an individual, group, virtual group, or the ACO as an APM Entity, and earn a MIPS performance category score. The ACO must publicly report the number of clinicians participating in the ACO that earn a MIPS PI category score. Specialists who participate in an ACO and report under MIPS will have the option to report under a MIPS Value Pathway (MVP) beginning in calendar year 2023.

CMS is proposing to modify the calculation of the proportion of dually eligible Medicare and Medicaid beneficiaries and the calculation of the proportion of assigned beneficiaries enrolled in Medicare Part D low-income subsidy (LIS) to use the number of beneficiaries rather than person years to calculate the proportion of beneficiaries who are enrolled in LIS or dually eligible in 2024. The agency proposes to use historical submission-level MIPS quality performance category scores to calculate the 40th percentile MIPS quality score starting in performance year 2024 — a rolling three-year average with a lag of one performance year. CMS believes this approach would better provide ACOs with the MSSP quality standard ACOs must meet to share in savings at the maximum sharing rate before the start of the performance year.

Starting in 2024, the agency plans to replace references to the case minimum requirement with a new requirement that ACOs must receive a MIPS quality performance score to meet the quality performance threshold. Further, CMS proposes to apply an MSSP scoring policy for excluded APP measures to alleviate adverse impacts to ACOs if one or more quality measure required under the APP is excluded.

MODIFICATIONS TO BENCHMARKING METHODOLOGY

The proposed rule attempts to build off 2023 final PFS efforts to reduce the impact of negative regional adjustments that result in higher benchmarks to promote participation in the MSSP. Beginning on Jan. 1, 2024, ACOs that would have previously faced a negative adjustment to their benchmark based on the 2023 PFS methodology will no longer receive a downward adjustment. ACOs eligible for the prior savings adjustment and that have a negative regional adjustment would also benefit as the negative regional adjustment will no longer offset the prior savings amount.

DETERMINING BENEFICIARY ASSIGNMENT

CMS proposes to include a third step to the step-wise assignment methodology in MSSP. The agency will modify the definition of assigned beneficiary, and the assignment methodology, to account for beneficiaries who receive primary care services from nurse practitioners, physician assistants, and clinical nurse specialists during the 12-month assignment window and had at least one physician visit in the previous 12 months. Starting Jan. 1, 2025, the agency will revise its a methodology to utilize the expanded window for assignment — a 24-month period including the applicable 12-month assignment window and the preceding 12 months. This would result in more beneficiaries in the assignable population and strengthen primary care. CMS proposes to expand the definition of primary care services used for assignment in MSSP regulations.

ADVANCE INCENTIVE PAYMENT (AIP) ADJUSTMENTS

Starting Jan. 1, 2024, CMS' proposal would make technical changes to AIP policies to support ACOs by allowing them to advance to two-sided model levels within the BASIC track's glide path starting in the third performance year of the agreement period in which they receive an AIP. The agency proposes to only recoup AIPs from the shared savings of an ACO that wants to renew early its participation in MSSP instead of recouping payments from the ACO. If finalized, CMS would immediately terminate AIPs for future quarters if the ACO voluntarily terminates participation. ACOs would be required to report spend plan updates and actual spend information to CMS, as well as publicly report this information. Lastly, ACOs would be able to request a review of their quarterly payment calculations. AIP payments may be used to invest in increased staffing, health care infrastructure, and the provision of care for underserved beneficiaries.

CHANGES TO ACO RISK ADJUSTMENT

For agreement periods beginning on Jan. 1, 2024, and in subsequent years, CMS proposes an approach that would modify the regional component of the three-way blended benchmark update factor by capping prospective Hierarchical Condition Category (HCC) risk score growth in an ACO's regional service area between benchmark year three and the performance year using a similar methodology to the 2023 PFS for capping ACO risk score growth with additional accounting for an ACO's aggregate market share. The cap of the regional risk score growth would apply independent of the cap on an ACO's prospective HCC risk score growth. The regional risk score growth cap would effectively increase the regional component of the update for ACOs in regions with an aggregate regional prospective HCC risk score growth above the cap. CMS believes capping the regional risk score growth will strengthen the incentive for ACOs to operate in regions with high-risk score growth and treat high-risk beneficiaries.

CMS finalized the 2024 CMS-HCC risk adjustment model, version 28 (v28), on March 31, 2023. Similar to the three-year phase-in of the revised 2024 CMS-HCC model for Medicare Advantage plans, CMS proposes to apply the same CMS-HCC risk adjustment model used in the performance year for all benchmark years starting on Jan. 1, 2024, and in subsequent years to establish, adjust, and update an ACO's benchmark. The underlying model will be 67% of the 2020 CMS-HCC risk adjustment model and 33% of the CMS-HCC risk adjustment model for the 2024 performance year. The CMS-HCC risk adjustment model is used to identify Medicare beneficiaries prospective HCC risk score for the corresponding benchmark or performance year.

SHARED GOVERNANCE REQUIREMENT

CMS intends to remove the option for ACOs to request an exception to the shared governance requirement that 75% control of the ACO's governing body must be held by ACO participants. The agency has not granted an ACO an exception to this requirement to date despite having the regulatory capacity to do so. CMS believes the 75% requirement is critical to ensure ACOs are participant-led.

2024 Quality Payment Program (QPP) Proposals

For 2024, CMS is attempting to align the QPP with other CMS initiatives such as the Universal Foundation and CMS National Quality Strategy. Many of the proposed changes are intended to continue the transition from FFS to value-based care within the QPP system. CMS estimates that 820,047 clinicians will be MIPS eligible, and 242,422 clinicians will achieve Qualifying APM Participant (QP) status in 2024.

Merit-based Incentive Payment System (MIPS)

CMS proposes to increase the MIPS performance threshold from 75 in the 2023 performance year to 82 points in the 2024 performance year. This proposed increase is a result of a methodological change in calculating the performance threshold. Instead of using a single prior period to establish the performance period, the agency is proposing to define "prior period" as three performance periods. For 2024, CMS is proposing to use the 2017-2019 performance periods. CMS estimates that approximately 54% of MIPS eligible clinicians would receive a negative payment adjustment of up to 9% for the CY 2024 performance period/2026 MIPS payment year if the policies proposed in this PFS are finalized.

QUALITY CATEGORY (30%):

CMS is proposing 200 quality measures for the 2024 performance period, an increase from 198 in 2023. Should the proposal be finalized, 14 quality measures (1 composite measure and 7 high priority measures) will be added, 12 quality measures will be removed, 3 quality measures will be partially removed (retained for MVP use only), and substantive changes to 59 existing quality measures will occur.

CMS plans to require groups, virtual group, subgroups, and APM Entities to contract with a Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey vendor to administer the Spanish survey translation to Spanish-preferring patients for those who report this measure. The agency is recommending participants administer the CAHPS for MIPS survey in other available translations. Regarding ICD-10 coding changes, CMS would eliminate the automatic 10% threshold of coding changes that triggers quality measure truncation or suppression and assess the impact of coding changes on a case-by-case basis.

COST (30%)

CMS proposes to calculate the cost improvement score for the cost performance category at the category level without using statistical significance starting with the 2023 performance period. Previous CMS policy had the cost improvement score calculated at the measure level. Five new episode-based cost measures have been proposed by the agency for 2024 with a 20-episode case minimum. If finalized, CMS will remove the acute inpatient medical condition measure *Simple Pneumonia with Hospitalization* for the 2024 performance period. Beginning in the 2023 performance period, the maximum cost improvement score of 1 percentage point would be available, while the maximum cost score for the 2022 performance period would be 0 percentage points.

IMPROVEMENT ACTIVITIES (15%)

The agency proposes to add five new improvement activities while modifying one existing activity and removing three current improvement activities. Four of the new activities proposed are related to CMS Health Equity, Increase All Forms of Accessibility to Health Care Services and Coverage.

PROMOTING INTEROPERABILITY (25%)

CMS proposes to revise the regulatory definition of CEHRT to be more flexible and reflect changes from the Office of the National Coordinator for Health Information Technology (ONC). CMS will move away from "editions" of certification criteria to require that participants meet certification criteria that will be maintained and updated in the regulations for MIPS, MVPs, and the APP. CMS is proposing five policy modifications to the Promoting Interoperability performance category:

- Lengthen the performance period from 90 days to 180 days;
- Modify the Query of Prescription Drug Monitoring Program (PDMP) measure exclusion;
- Provide a technical update to the e-Prescribing measure's description;
- Modify the Safety Assurance Factors for Electronic Health Record Resilience (SAFER) Guide measure to require MIPS eligible clinicians to affirmatively attest to completion of the self-assessment of their implementation of safety practices. Clinicians only need to review the High Priority Practices SAFER guide; and,
- Continue to reweight this performance category at zero percent for clinical social workers for the 2024 performance year.

While automatic reweighting will apply to clinical social workers for 2024, it will not continue to automatically reweight for physical therapists, occupational therapists, qualified speech-language pathologists, clinical psychologists, and registered dietitians or nutrition professionals in 2024.

DATA COMPLETENESS THRESHOLD

The data completeness threshold will be 75% for the 2024 and 2025 performance periods as finalized in the 2023 PFS for MIPS, MVPs, and the alternative payment model (APM) performance pathway. This threshold applies for eCQMs, MIPS CQMs, and QCDR measures, Medicare Part B patients for Medicare Part B claims measures (small practices only), and beneficiaries that meet the proposed definition of a beneficiary for Medicare CQMs (MSSP ACOs only). CMS is proposing to keep the data completeness threshold at 75% for 2026 performance period and increase it to 80% for the 2027 performance period.

TARGETED REVIEW

There is currently a 60-day period under MIPS, MVPs, and the APP to request a targeted review. CMS proposes to open the targeted review submission period on the release of MIPS final scores and keep it open for 30 days after MIPS payment adjustments are released. The agency believes this will maintain an approximate 60-day review period. If CMS requests additional documentation under the targeted review process, the information must be received by CMS within 15 days of the receipt of a request. Subgroups and virtual groups may request a targeted review for the 2023 MIPS performance period.

QUALIFIED CLINICAL DATA REGISTRIES (QCDRS) AND QUALIFIED REGISTRIES

CMS proposes the following changes to QCDRs and Qualified Registries:

- Updating self-nomination requirements to ensure that QCDRs and qualified registries include MVP titles and measure and activity identifiers for improvement activities and PI performance categories;
- Adding "measure submitted after self-nomination" to the list of reasons for rejecting a QCDR measure;
- Requiring QCDRs to publicly post their approved measure specifications for the duration of the performance and associated submission period;
- Requiring QCDRs and qualified registries attest to the accuracy of their information in qualified postings, and attest they have the ability to provide CMS with access to review the data; and,
- Specifying the required sampling methodology for third party intermediary data valuation audits.

THIRD PARTY INTERMEDIARIES

CMS is proposing to eliminate the health information technology (IT) vendor category starting in the 2025 performance period. Health IT vendors would still be able to participate in MIPS as third-party intermediaries by self-nominating to become a QCDR or a qualified intermediary, or they could continue to support clinicians in sign in and upload or attest submission types. This is in response to CMS observing situations where health IT vendors submitted inaccurate or unusable data.

PUBLIC REPORTING ON COMPARE TOOLS

CMS publicly reports telehealth indicators for clinicians providing telehealth services on individual clinician's profile pages. The agency is proposing to modify how it identifies telehealth services by using the most recent POS and claims modifier codes available at the time the information is refreshed on clinician profile pages. The proposed rule would amend certain procedure information (utilization data) on clinician pages by adding procedure grouping flexibility for CMS to create clinically meaningful categories, publicly reporting Medicare Advantage data as appropriate, and removing the policy to publicly report on the Provider Data Catalog (PDC) and provide a downloadable dataset reflecting utilization data.

MIPS Value Pathways (MVPs)

CMS proposes to consolidate previously finalized Promoting Wellness MVP and Optimizing Chronic Disease Management into a single primary care MVP. The agency intends to add five new MVPs to be available for reporting in the 2024 performance year:

- Focusing on Women's Health;
- Quality Care for the Treatment of Ear, Nose, and Throat Disorders;
- Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV;
- Quality Care in Mental Health and Substance Use Disorders; and,
- Rehabilitative Support for Musculoskeletal Care.

SUBGROUP REPORTING

CMS is proposing several changes to its policies on the subgroup reporting option for MVPs. The agency intends not to calculate a facility-based score at the subgroup level as there is not a facility-based MVP. A facility-based clinician or group would still report under an MVP. Starting with the 2023 performance year, subgroups would receive their affiliated group's complex patient bonus. Finally, subgroups would only receive performance category reweighting based on any reweighting applied to its affiliated group.

Advanced Alternative Payment Models (APMs)

USE OF CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY (CEHRT)

Under current regulations, 75% of eligible clinicians in each participating APM Entity are required to use CEHRT in order for the APM to be considered an Advanced APM. CMS is proposing to remove the 75% threshold and to specify that the APM must require all eligible clinicians to use CERHT to be an Advanced APM beginning in 2024.

INCENTIVE PAYMENT AND CONVERSION FACTOR

Congress extended the APM Incentive Payment at 3.5% of the clinician's estimated aggregate payments for covered professional services for 2023. The APM Incentive Payment will end after the 2023 performance year. For 2024, QPs would receive a higher PFS update, or "qualifying AP conversion factor," of 0.75% compared to non-QPs who will receive a 0.25% PFS update. Additionally, QPs would still be excluded from MIPS reporting and payment adjustments in 2024.

QUALIFYING PARTICIPATION THRESHOLD

CMS is proposing to make QP determinations at the individual clinician level only, as opposed to the APM Entity level. Congress froze QP thresholds at 2020 levels for the last three years. CMS intends to increase the Medicare payments and Medicare patients' thresholds beginning in the 2024 performance period (2026 payment year). The QP threshold for Medicare payments would increase from 50% to 75%, while the partial QP threshold would increase from 40% to 50%. The Medicare patients QP threshold would increase from 35% to 50% and the partial QP threshold would increase from 25% to 35%.

PROPOSED 2024 MEDICARE PHYSICIAN PAYMENT AND QUALITY REPORTING CHANGES

Medicare Option - Payment Amount Method

Performance Year / Payment Year	2021 / 2023 (Percents)	2022 /2024 (Percents)	2023 / 2025 (Percents)	2024 / 2026 and later (Percents)
QP Payment Amount Threshold	50	50	50	75
Partial QP Payment Amount Threshold	40	40	40	50

Medicare Option - Patient Count Method

Performance Year / Payment Year	2021 / 2023 (Percents)	2022 /2024 (Percents)	2023 / 2025 (Percents)	2024 / 2026 and later (Percents)
QP Payment Amount Threshold	35	35	35	50
Partial QP Payment Amount Threshold	25	25	25	35

All-Payer Combination Option - Payment Amount Method

Performance Year / Payment Year	2021 / 2023 (Percents)		2022 /2024 (Percents)		2023 / 2025 (Percents)		2024 / 2026 and later (Percents)	
QP Payment Amount Threshold	50	25	50	25	50	25	75	25
Partial QP Payment Amount Threshold	40	20	40	20	40	20	50	20
	Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum

All-Payer Combination Option - Patient Count Method

Performance Year / Payment Year	2021 / 2023 (Percents)		2022 /2024 (Percents)		2023 / 2025 (Percents)		2024 / 2026 and later (Percents)	
QP Payment Amount Threshold	35	20	35	20	35	20	50	20
Partial QP Payment Amount Threshold	25	10	25	10	25	10	35	10
	Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum	Total	Medicare Minimum

Source: Proposed 2024 Final Physician Fee Schedule

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