

CY 2024 Medicare Physician Fee Schedule Final Rule Summary

On November 2, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (MPFS) final rule for CY 2024 (CMS-1784-F). The rule updates payment policies and payment rates for Part B services furnished under the MPFS, as well as makes changes to the Quality Payment Program (QPP). The rule in its entirety and the addenda, including Addendum B, which lists the final RVUs for each CPT® code can be found [here](#).

CMS has finalized several significant policy changes, including the implementation of HCPCS G2211, an add-on for services associated with complex patient care; reimbursement for health-related social needs services; and the maintenance of several telehealth payment policies until the end of 2024. The following summarizes the major policies of the rule. Note that the page numbers listed in this document refer to the [display copy](#) of the final rule.

Regulatory Impact Analysis

Highlight: Conversion factor set for a decrease again for CY 2024

Conversion Factor for 2024

The conversion factor for 2024 is set to decrease by approximately **3.37% from \$33.8872 to \$32.7442**. This 2024 conversion factor is derived from a statutory 0% update, a negative 2.18% RVU budget neutrality adjustment, and the expiration of 1.25% of the payment increase as provided by the Consolidated Appropriations Act (CCA) of 2023. Without Congressional action, CMS cannot implement policy to avert the cut to the conversion factor.

Specialty Level Impact of the Final Rule – p. 1,950

The impact on group practices and individual physicians varies based on practice type and the mix of patients and services provided to those patients. The following table outlines estimated specialty level impacts from Table 118 of the rule, also shown in Appendix D of this document and includes some specialties with the greatest impact, both positive and negative for comparison purposes. The impact table estimates include the effects of the implementation of G2211 and other policy changes in the fee schedule and does not include the expiration of the 1.25% payment increase implemented in the CCA of 2023.

Table 1: CY 2024 Estimated Impact Total Allowed Charges by Specialty for Selected Specialties

Specialty	Medicare Allowed Charges (millions)	Work RVU Impact	PE RVU Impact	MP RVU Impact	Overall Impact
Endocrinology	\$507	1%	1%	0%	3%
Hematology/Oncology	\$1,591	1%	0%	0%	2%
Rheumatology	\$509	1%	1%	0%	2%
Internal Medicine	\$9,618	0%	1%	0%	1%
Urology	\$1,623	0%	0%	0%	1%



Gastroenterology	\$1,474	0%	0%	0%	0%
Allergy/Immunology	\$216	0%	-1%	0%	-1%
Infectious Diseases	\$573	-1%	0%	0%	-1%
Vascular Surgery	\$1,009	0%	-3%	0%	-3%
Interventional Radiology	\$457	-1%	-3%	0%	-4%

Determination of Practice Expense RVUs – p. 34

Highlight: No change in the MEI methodology while CMS waits for updated practice expense data from the AMA.

Last year, CMS finalized policy to rebase and revise the Medicare Economic Index (MEI) to reflect current market conditions in the delivery of physician services. However, after receiving comments on this issue, and considering the American Medical Association’s (AMA) ongoing project of updating and collecting new data through the Physician Practice Information Survey, CMS delayed using rebased and revised MEI data for 2024 rate setting.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act – p. 97

Highlight: CMS updates telehealth regulations to be consistent with Consolidated Appropriations Act, 2023 extensions and will continue to pay for telehealth services at the non-facility rate if the place of service (POS) code indicates the originating site is the patient’s home.

CMS Adds New Code for Assessing Social Determinants of Health (SDOH) to the Telehealth List
 CMS finalized the addition of HCPCS code G0136 (*Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment tool, 5-15 minutes*) to the telehealth list on permanent basis. This service requires a face-to-face encounter between a clinician and beneficiary during which the practitioner uses their clinical judgement to determine whether to complete the SDOH screening with or without direct patient interaction. The service must be delivered on the same day as an evaluation and management (E/M) service, which can be delivered via telehealth.

Implementation of Provisions of the CAA, 2023

The CAA, 2023 extended certain telehealth policies through December 31, 2024. CMS seeks to update its regulations to reflect this extension for the following flexibilities: (1) waiver of in-person requirements for mental health telehealth; 2) the waiver of originating site requirements; (3) the expansion of telehealth practitioners to include occupational therapists, physical therapists, speech-language pathologists, and audiologists as well as marriage and family therapists and mental health counselors as of January 1, 2025; and (4) audio-only services.

In the CY 2023 final rule, CMS established POS 10 for telehealth provided in the patient’s home. The agency finalized that claims billed with POS 10 will be paid at the non-facility rate beginning in CY 2024 in recognition that practitioners will need to maintain an in-person practice setting in addition to providing telehealth services. Claims billed with POS 02 (Telehealth Provided Other than



in Patient's Home) will continue to be paid at the facility rate beginning on January 1, 2024. CMS believes, for these non-home originating sites, such as physician's offices and hospitals, the facility rate more accurately reflects the PE of these telehealth services. Through this policy, the agency seeks to protect access to mental health and other telehealth services by aligning with the telehealth-related flexibilities that were extended via the CAA, 2023.

Other Non-Face-to-Face Services Involving Communications Technology under the PFS
Direct Supervision

With end of the public health emergency, CMS was concerned about the expiration of policy that allowed direct supervision via a virtual presence. Therefore, the agency finalized that direct supervision may be defined as presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2024, to align with the extension of other telehealth flexibilities through that date.

Supervision of Residents in Teaching Settings

In the CY 2021 final rule, CMS included a policy to allow teaching physicians to supervise residents virtually for services delivered in residency training sites that are located outside of an Office of Management and Budget-defined metropolitan statistical area (MSA) after the end of the public health emergency and now seeks to align this policy with other telehealth policies. The agency has finalized that it is permissible for the teaching physician to have a virtual presence in all teaching settings for services provided virtually through December 31, 2024. The virtual presence policy would continue to require real-time observation by the teaching physician and would exclude audio-only technology. The documentation must include whether the physician was physically present or present virtually at the time of the telehealth service. CMS is exercising enforcement discretion to allow teaching physicians in all residency training sites to be present virtually for services furnished involving residents through December 31, 2023.

Clarifications for Remote Monitoring Services

Under current policy, remote physiologic monitoring (RPM) services may only be delivered to established patients now that the public health emergency has expired. Patients who received initial remote monitoring services during the public health emergency are now considered established patients for the purpose of this policy.

The agency is not extending its interim policy to permit billing for remote monitoring codes when less than 16 days of data are collected within a given 30-day period. This 16-day monitoring requirement was reinstated when the public health emergency expired and applies to RPM and remote therapeutic monitoring (RTM) services. This requirement applies to the following CPT codes: 98976, 98977, 98978, 98980, and 98981.

Use of RPM, RTM, in conjunction with other services

Either RPM or RTM, but not both, may be billed concurrently with the following care management services: Chronic Care Management (CCM), Transitional Care Management (TCM), Behavioral Health Integration (BHI), Principal Care Management (PCM), and Chronic Pain Management (CPM). CMS intends to provide maximum flexibility for practitioners to select the appropriate mix of care management services without creating program integrity concerns.



Other Clarifications for Appropriate Billing

CMS has received inquiries regarding the use of remote monitoring during surgical global periods and proposes to clarify that RPM or RTM services may be furnished and paid separately from the global period if the requirements for the global and remote monitoring service are both met.

Telephone Evaluation and Management Services

Since the start of the public health emergency, CMS has separately paid for CPT codes 99441 through 99443 and 98966 and 98968, which describe E/M and assessment and management services delivered via telephone. The agency will continue to assign an active payment status for these services through CY 2024 to align with the telehealth flexibilities extended through 2024.

Telehealth Originating Site Facility Fee Payment Amount Update

For CY 2024, CMS finalized a payment amount \$29.96 for HCPCS code Q3014 (*Telehealth originating site facility fee*).

Payment for Caregiver Training Services (CTS) – p. 285

In recent years, CMS has been exploring policies to increase support and training needed when caring for patients that have certain illnesses and diseases. Beginning in 2024, and in alignment with the [White House executive order](#) to increase access to high quality care and increase support for caregivers, CMS will make payment for CTS by establishing an active payment status for CPT codes 96202 (*Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes*) and 96203 (*each additional 15 minutes*). Payment for caregiver training services will go into effect January 1, 2024.

Additionally, the agency finalized payment for new codes 97550 (*Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes*), 97551 (*each additional 15 minutes*), and 97552 (*Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face with multiple sets of caregivers*).

After considering public comments, the agency revised the definition of caregiver in the final rule, which now reads as a caregiver is “an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation” and “a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition”.

Evaluation and Management (E/M) Visits – p. 422



Highlight: Amid controversy and after a three-year delay, CMS finalizes implementation of G2211, which is a code that will be used to pay for complex care services delivered by a provider with an ongoing relationship with the patient.

Office/Outpatient (O/O) E/M Visit Complexity Add-on Implementation

Background: In CY 2021, CMS finalized the O/O E/M visit complexity add-on code G2211 to describe intensity and complexity inherent to O/O E/M visits for 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, or complex condition. The agency planned for the add-on code to be reported with all O/O E/M service levels. However, Congress delayed the code's implementation until January 1, 2024.

Since the delay of the code's implementation and during the comment period for the CY 2024 MPFS rule, CMS received feedback from stakeholders on several issues: when it would be appropriate to report G2211, the redistributive impact of its implementation, the overlap of services between G2211 and other E/M codes, the definition of "complex and serious", cost sharing implications for beneficiaries, and administrative burden of reporting the code, among many other issues.

CMS addressed some comments in the final rule, but of note, the agency believes that this new G code will address "longstanding issues with coding and valuation of O/O E/M services that do not fully distinguish and account for resource costs for primary care and other longitudinal care for complex patients, but specifically for visits associated with longitudinal, non-procedural care when compared to work RVUs for procedural services and visits furnished in association with procedural-based care." The agency also believes that the work and expertise of those who primarily bill E/M codes for their services are "left relatively underrecognized within the previous and current E/M coding and valuation structure."

Despite the concerns from some stakeholders, the agency has finalized the implementation of G2211, as an add-on code to office visit E/M services, effective January 1, 2024. G2211 will have a work RVU of 0.33 and will have a payment of approximately \$16.00. The code is not payable when the office visit is reported with payment modifier -25, meaning G2211 cannot be billed when an office visit is billed on the same day as a procedure or other service delivered by the same practitioner.

The agency also maintained the proposed utilization assumptions that G2211 will be billed with 38% of all office visit E/M visits, at least initially.

Finally, to provide clarity as to when G2211 should be billed, the agency has explained that the single most important factor when deciding to bill for services associated with the code is the ***relationship*** between the patient and the practitioner. When the practitioner is "the continuing focal point for all health care services that the patient needs," that is how it should be decided to bill for the service or not. For example, if a patient reports to the office with a sinus infection, and the practitioner is the focal point for all health care services and needs of this patient, then it would be appropriate to report the complex add-on code with the E/M service. As the agency has described it, it is the "cognitive load of the continued responsibility of being the focal point for all needed services for this patient" that determines if the complex care add-on code is appropriate.



Request for Comment About Evaluating E/M Services More Regularly and Comprehensively

CMS requested comment about the range of approaches that the agency could take to improve the accuracy of valuing services and was particularly interested in how E/M services might be evaluated with greater specificity, more regularly and comprehensively.

CMS received comments that provided the agency with opinions and options about how to best value services under the MPFS. As expected, the comments were divided in support of the AMA RUC process, and those that would welcome another approach such as an expert panel that would fall under CMS's purview. Others recommended that CMS use real-world data to value physician services, and not data that is derived from physician surveys.

The agency welcomed all the comments and thoughtful responses and noted that they will consider all comments to inform future rulemaking.

Split/Shared Visits – p. 468

A split/shared visit is an E/M service performed by a physician and a nonphysician practitioner (NPP) in the same group practice in the facility setting where the “incident to” policy does not apply. CMS proposed, and delayed multiple times, that the “substantive portion of the service” which determines the practitioner that bills for the service—the physician or the NPP—would be defined by the practitioner that provides more than half the service using time as the deciding factor. After review of comments, and in consideration of the revision to coding guidance in the 2024 CPT coding manual, the agency has finally defined the substantive portion to mean “**more than half of the total time spent by the physician and NPP performing the split (or shared) visit, or a substantive part of the medical decision making as defined by CPT**”. The revised definition and hence payment policy will become effective January 1, 2024.

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

Highlight: The agency will pay for new services to provide greater access to care that includes payment for community health worker (CHW) services.

Community Health Integration Services (CHI) – p. 307

The agency has taken steps to recognize the valuable services that CHWs provide when assisting Medicare beneficiaries with services not typically reimbursed on the MPFS. Therefore, CMS finalized the creation of two new HCPCS codes to describe services performed by “certified or trained auxiliary personnel, which may include a CHW, incident to the professional services and under the general supervision of the billing practitioner.”

The services described by the new codes are expected to be provided monthly after an E/M visit (CHI initiating visit) in which the provider identifies the need for CHI based on the presence of certain social determinants of health (SDOH) factors. The framework for the provision of these services is like that for care management services. The first visit, the CHI initiating visit would “serve as the prerequisite for billing CHI services by the billing practitioner” whereby they would identify and assess the SDOH needs of the patient that limit the practitioner’s ability to diagnose and treat the patient’s medical condition. Any of the follow-up CHI performed by the CHW or other authorized personnel



may bill incident to the professional services of the practitioner who billed the initiating visit. For the code descriptors, see 317 of the display copy of the final rule.

Social Determinants of Health – Establishment of a HCPCS G Code – p. 343

One of the pillars of the Biden administration has been the development of policies and regulations that address health equity and fair access to government funded programs. As a part of this initiative, the agency has finalized the creation and payment for HCPCS code G0136 - *Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months.*

The code was developed to account for time and other resources required when providers are assessing their patient's SDOH, as those factors usually affect the outcome of treatment. After consideration of comments, CMS will **NOT** require that the risk assessment be performed on the same day as an E/M service. The required elements of the assessment however, remained unchanged from the proposed rule and must include "administration of a standardized, evidence-based SDOH risk assessment tool that has been evaluated and validated through research, and includes the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties."

When SDOH needs are identified through the risk assessment, those needs must be documented in the medical record. While not required, the agency is encouraging the use of ICD-10-CM Z codes (Z55-Z65) to document findings of the assessment within the patient's medical record. CMS finalized adding SDOH Risk Assessment as an optional, additional element of the annual wellness visit that would include additional payment for the provision of this service. There would be no cost-sharing for the beneficiary.

Finally, the agency was appreciative of the thoughtful and thorough comments on the frequency and limitations of the use of the SDOH G code. After review of comments, **the agency has finalized a limitation on payment for the SDOH risk assessment service of once every six months per practitioner per beneficiary.**

Principal Illness Navigation – p. 361

Included in this final rule and conforming with other finalized policies that expand care for many different types of populations, CMS finalized HCPCS codes and payment to describe services associated with the care of patients with a "serious, high-risk disease expected to last at least 3 months, that places the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, functional decline, or death, and the condition requires development, monitoring, or revision of a disease-specific care plan, and may require frequent adjustment in the medication or treatment regimen, or substantial assistance from a caregiver."

The new services, Principal Illness Navigation (PIN), are like CHI services, but the patient may not necessarily have SDOH that affect their care and as such may involve "service elements to describe identifying or referring the patient to appropriate supportive services, providing information/resources to consider participation in clinical research/clinical trials, and inclusion of lived experience or training in the specific condition being addressed." The services may be billed incident to physician services and may be provided under general supervision. The code descriptions can be found on page 373 of



the final rule. The service described by code G0023 is billed 60 minutes per calendar month, and the second code, G0024 is billed each additional 30 minutes per calendar month.

Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Medical Services – p. 574

Highlight: CMS continues to recognize the importance of dental care in the overall health of Medicare beneficiaries.

Request for Comment Regarding Dental Services Possibly Inextricably Linked to Other Medicare-Covered Services

Stakeholders encouraged CMS to consider the importance of access to oral health care for individuals with chronic auto-immune conditions and other chronic disease conditions, including diabetes.

After reviewing comments, CMS is not expanding the examples of covered medical services to include the conditions and procedures suggested. The information provided did not establish an inextricable link between dental services and a covered medical service such that dental services would not be in connection with the care, treatment, filling, removal, or replacement of teeth or structures supporting the teeth. Stakeholders should submit medical evidence to support this link, as set out in the final rule.

Request for Information on Implementation of Payment for Dental Services Inextricably Linked to Other Specific Covered Services

In the proposed rule, CMS sought comments on several policies related to the implementation of payment for dental services. In the CY 2023 MPFS final rule, the agency codified the policy on payment for dental services and added examples of circumstances where payments can be made for certain dental services, including a dental exam and services to diagnose and eliminate an oral or dental infection prior to organ transplant, cardiac valve replacement, or valvuloplasty procedure. The agency provided examples of dental services that could be furnished to eradicate infection, such as diagnostic services, evaluations and exams, extractions, restorations, periodontal therapy, or endodontic therapy. The agency maintains that additional dental services, such as a dental implant or crown, may not be immediately necessary to eliminate or eradicate the infection. Therefore, no Medicare payment is available for additional services that are not immediately necessary to eliminate or eradicate the infection. The agency also clarified that they will not cover services for the preparation or placement of dentures.

The agency appreciated the comments on implementation of the dental policies and will work with the MACs and other interested parties to address issues raised in the comments. CMS plans to provide guidance and further rulemaking as necessary as the policy is implemented. The agency will also monitor service utilization to identify any concerns about consistency of claims processing and adequacy of access.

In order to be considered for CY 2025 rulemaking, submissions through the public process for recommendations on payment for dental services must be received by February 10, 2024 to MedicarePhysicianFeeSchedule@cms.hhs.gov, with the subject line “dental recommendations for CY 2025 review”.



Diabetes Self-Management Training (DSMT) Services by Registered Dietitians and Nutrition Professional, and DSMT Telehealth Services – p. 324

Highlight: CMS proposes that all ten hours of DSMT may be provided via telehealth.

In keeping with the theme to increase access to services and to correct confusion surrounding billing guidelines for which providers may bill for DSMT services, CMS will amend regulations to clarify the following:

- A registered dietician or nutrition professional must personally perform medical nutrition therapy services to bill for those services, however;
- When acting as a DSMT certified provider, the registered dietician or nutrition professional may bill on behalf of the entire DSMT entity “regardless of which professional personally delivered the services.”

In addition to clarifying billing requirements for DSMT, the agency has finalized that the full 10 hours of DSMT may be provided via telehealth. Currently, one hour of the initial ten hours of DSMT training must be provided in person for proper insulin injection training and one hour of the two-hour follow-up must be devoted to injection training. However, given the recent expansion and success of using telehealth during the COVID-19 pandemic, the agency believes that injection training can be safely provided via telehealth, thereby allowing the entire initial training and any follow-up training via telehealth.

Drugs and Biological Products Paid Under Medicare Part B – p. 659

Highlight: Policies related to the Inflation Reduction Act are codified.

Provisions from the Inflation Reduction Act Relating to Drugs and Biologicals Payable Under Medicare Part B

The Inflation Reduction Act (IRA) included several provisions that impact payment limits or beneficiary out-of-pocket costs for certain drugs payable under Part B. The agency finalized the proposal to codify these provisions in regulation. Two provisions that affect payment limits for biosimilar biological products (“biosimilars”) are as follows:

- Section 11402 amends the payment limit for new biosimilars furnished on or after July 1, 2024, during the initial period when ASP data is not available
- Section 11403 revises the payment limit for certain biosimilars with an average sales price (ASP) that is not more than the ASP of the reference biological for a period of 5 years (CMS implemented this section with program instructions)

Two provisions make statutory changes that affect beneficiary out-of-pocket costs for certain Part B drugs are as follows:

- Section 11101 of the IRA requires that beneficiary coinsurance for a Part B rebatable drug be based on the inflation-adjusted payment amount if the Medicare payment amount for a calendar quarter exceeds the inflation-adjusted payment amount, starting on April 1, 2023 (CMS issued initial guidance to implement this provision)
- Section 11407 of the IRA provides that for insulin furnished through an item of durable medical equipment (DME) on or after July 1, 2023, the deductible is waived, and the coinsurance is limited to \$35 for a month’s supply of insulin furnished through a covered DME (CMS implemented this section with program instructions)



Payment for Drugs Under Medicare Part B During an Initial Period

Section 11402 of the IRA required that for new biosimilars furnished on or after July 1, 2024, during the initial period when ASP data is not available, the payment limit for the biosimilar will be the lesser of: 1) an amount not to exceed 103 percent of the Wholesale Acquisition Cost (WAC) of the biosimilar or the Medicare Part B drug payment methodology, or 2) 106 percent of the lesser of the WAC or ASP of the reference biological, or in the case of a selected drug during a price applicability period, 106 percent of the maximum fair price of the reference biological. CMS finalized the proposal to codify these changes in regulation.

Inflation-adjusted Beneficiary Coinsurance and Medicare Payment for Medicare Part B Rebatable Drugs

Section 11101 of the IRA requires the payment of rebates into the Supplementary Medical Insurance Trust Fund for Part B rebatable drugs if the payment limit amount exceeds the inflation-adjusted payment amount. CMS previously issued final guidance for computing the inflation-adjusted beneficiary coinsurance. Additional information on implementation of this section can be found [here](#).

For Part B rebatable drugs furnished on or after April 1, 2023, in quarters where the amount specified in the statute exceeds the inflation-adjusted payment amount, the coinsurance will be 20 percent of the inflation-adjusted payment amount for that quarter. The agency finalized the proposal to codify the coinsurance amount for Part B rebatable drugs.

The section also requires that if the inflation-adjusted payment amount of a Part B rebatable drug exceeds the payment amount described in the statute, then the Part B payment will equal the difference between the payment amount and the inflation-adjusted coinsurance amount. CMS finalized the proposal to codify the Medicare payment for Part B rebatable drugs.

Limitations on Monthly Coinsurance and Adjustments to Supplier Payment Under Medicare Part B for Insulin Furnished through Durable Medical Equipment

Part B covers drugs furnished through covered DME equipment. For example, Insulin that is administered through a covered DME, such as a durable insulin pump, is covered under this benefit. Section 11407 of the IRA made three changes to beneficiary payment for insulin furnished through covered DME.

- A waiver of the Part B deductible for insulin furnished through covered DME on or after July 1, 2023.
- A \$35 limit on the beneficiary coinsurance amount for a month's supply of insulin furnished on or after July 1, 2023.
- A requirement that the Secretary increase the Part B payment to above 80 percent in cases where the coinsurance amount for insulin equals less than 20 percent of the payment amount to pay for the full difference between the payment amount and coinsurance; this ensures that the supplier is not responsible for the reduction in the beneficiary coinsurance amount.



CMS implemented these provisions through program instructions, which can be found [here](#). The agency finalized the proposal to codify the provisions from the program instruction in regulation. This includes the following provisions:

- The \$35 coinsurance limit applies to the duration of the calendar month in which the date of service occurs, which is the date that the beneficiary receives the insulin, or it is shipped.
- When a 3-month supply is billed for insulin, then a coinsurance limit of \$105 applies for the 3-calendar month period.
- MACs will ensure that the coinsurance does not exceed \$35 for a 1-month supply or \$105 for a 3-month supply for claims billing insulin administered through covered DME.

Request for Information: Drugs and Biologicals which are not Usually Self-Administered by the Patient, and Complex Drug Administration Coding

Medicare is allowed to pay for services and supplies, including drugs and biologicals, which are not usually self-administered by the patient and that are furnished as “incident to” a physician’s professional service. CMS has provided definitions and guidance to the MACs about determining if a drug is usually self-administered and publishing this information on their websites as the self-administered drug (SAD) list. Stakeholders have requested that CMS update and clarify the SAD list guidance and have also raised concerns that non-chemotherapeutic complex drug administration payments are inadequate and do not reflect the resources used to furnish infusion services.

CMS will consider the comments received for future rulemaking and guidance.

Requiring Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs to Provide Refunds with Respect to Discarded Amounts

Section 90004 of the Infrastructure Investment and Jobs Act (“the Infrastructure Act”) added a new requirement for manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug, referred to as a “refundable drug.” The refundable amount is the amount of discarded drug that exceeds an applicable percentage of total charges for the drug in each calendar quarter; the applicable percentage is required to be at least 10 percent.

CMS previously finalized several policies to implement this new requirement in the CY 2023 MPFS final rule. The agency finalized several more policies in this final rule:

- The date of the initial report to manufacturers;
- The date for subsequent reports to manufacturers;
- The method for calculating refunds for discarded amounts in lagged claims data;
- The method for calculating refunds when there are multiple manufacturers for a refundable drug;
- Increased applicable percentages for certain drugs with unique circumstances; and
- A future application process for manufacturers to apply for an increased applicable percentage for a drug

Medicare Diabetes Prevention Program (MDPP) – p. 1,273

Highlight: CMS creates a fee for service model for the MDPP to improve beneficiary retention in the program.



The MDPP is an expansion in duration and scope, of the Diabetes Prevention Program (DPP) model test and was established as an “additional preventive service” covered by Medicare and not subject to beneficiary cost-sharing in 2017.

After evaluating the current performance-based payment structure, CMS determined the attendance-based performance payments were not working since the structure did not incentivize beneficiary retention; therefore, CMS has finalized fee-for-service payments for beneficiary attendance, allowing for up to twenty-two attendance-based payments versus the five current payments. This new structure will allow beneficiaries to attend a maximum of twenty-two sessions during the core services period, including up to sixteen sessions in months one through six and up to six sessions in months seven through twelve.

Specifically, CMS created an Attendance Payment, defined as a payment that is made to a MDPP supplier for furnishing services to a MDPP beneficiary when the beneficiary attends a core maintenance session. The agency also finalized that suppliers may receive an Attendance Payment after they submit a claim for each MDPP session, starting with the first core session using a new HCPCS G-code, *Behavioral counseling for diabetes prevention, in-person, group, 60 minutes*, or *Behavioral counseling for diabetes prevention, distance learning, 60 minutes*, for MDPP dates of service on or after January 1, 2024.

The agency removed the performance-based payments for attendance but retained a performance goal defined as a weight loss goal that the MDPP beneficiary must achieve during the service period. CMS also retained the diabetes risk-reduction performance payments, which includes payments for 5% and 9% weight loss, which will enable the agency to continue to pay for outcomes. The agency finalized a new HCPCS G-code, “Maintenance of 5 percent weight loss from baseline, months 7-12” to be submitted along with the monthly session claim for beneficiaries who have met the 5 percent weight loss performance goal, for whom the one-time claim for 5 percent weight loss has been submitted. CMS also created a G-code to submit when the 9% weight loss goal is achieved. Table 49 extracted from the rule shows the final payment and the G code descriptors for use in the program.



TABLE 49: Changes to MDPP Payment Structure to include Attendance-Based Service Payments and Diabetes Risk Reduction Performance Payments

HCPCS G-Code	Payment Description*	CY 2024
G9886*	Behavioral counseling for diabetes prevention, in-person, group, 60 minutes	\$25
G9887*	Behavioral counseling for diabetes prevention, distance learning, 60 minutes	\$25
G9880	5 percent WL Achieved from baseline weight	\$145
G9881	9 percent WL Achieved from baseline weight	\$25
G9888**	Maintenance 5 percent WL from baseline in months 7-12	\$8
G9890	Bridge Payment	\$25
Subtotal Maximum Attendance-Based Payment		\$550
Total Maximum Payment		\$768

*Medicare pays up to 22 sessions billed with codes G9886 and G9887, combined, in a 12-month period:

Months 1-6: 1 in-person or distance learning session every week (max 16 sessions)

Months 7-12: 1 in-person or distance learning session every month (max 6 sessions)

** Suppliers must submit claim for 5 percent weight loss (G9880) prior to submitting claims for the maintenance 5 percent WL from baseline in months 7-12 (G9888).

Additionally, the agency will extend the flexibilities allowed under the COVID-19 public health emergency for four years until December 31, 2027, including:

- Alternatives to the requirement for in-person weight measurement;
- Elimination of the maximum number of virtual services. During this four-year period, MDPP suppliers may provide virtual services if they are delivered in a manner consistent with the Centers for Disease Control and Prevention’s (CDC) Diabetes Prevention Recognition Program (DPRP) standards for distance learning;

According to the CDC, distance learning involves “a yearlong National DPP lifestyle change program delivered 100% by trained lifestyle coaches via remote classroom or telehealth. The lifestyle coach provides live (synchronous) delivery of session content in one location and participants call-in or video-conference from another location.” CMS created a G-code for “distance learning” to track sites more accurately from which distance learning occurs; the number of MDPP sessions delivered by distance learning; monitor the expanded model for fraud, waste, or abuse; and evaluate the impact of distance learning and in-person delivery modalities of MDPP relative to cost-saving and diabetes risk reduction among participants. This G-code for “distance learning” should be used instead of the virtual modifier (VM) that had been used to document the virtual make-up sessions allowed during the public health emergency. Note that the agency will not remove the VM modifier if they propose to allow online make-up sessions in future rulemaking.

The extended flexibilities will only be available to MDPP suppliers that have and maintain the CDC DPRP in-person recognition.

Medicare Part B Payment for Preventive Vaccine Administration Services – p. 1,249

Highlight: Vaccine payment rates stay the course



As finalized in 2023, the agency will continue to update payment rates for preventative vaccines using the percentage increase in the MEI. Those base payments will then be adjusted by a geographic locality adjustment to account for differences in costs across the US. There is one payment amount per home visit for the administration of the four covered preventative vaccines (pneumococcal, influenza, hepatitis B, and COVID-19 vaccine).

Expanded Diabetes Screening and Diabetes Definitions – p. 1,401

Highlight: CMS simplifies definitions and expands coverage of screening.

CMS has finalized changes that will: (1) expand coverage of diabetes screening tests to include the Hemoglobin A1C (HbA1c) test; (2) expand and simplify the frequency limitations for diabetes screening; and (3) simplify the regulatory definition of “diabetes” to simply mean diabetes mellitus, a condition of abnormal glucose metabolism, for diabetes screening as part of Medical Nutrition Therapy (MNT) and Diabetes Outpatient Self-Management Training (DSMT) services.

The agency believes that the changes will expand and simplify coverage for diabetes screening to align with the administration’s strategic pillar to advance health equity by addressing underlying health disparities.

Medicare Shared Savings Program – p. 828

The Medicare Shared Savings Program (MSSP) allows eligible healthcare providers, such as physicians, hospitals, and others, to form or join an accountable care organization (ACO). By doing so, they agree to take responsibility for the overall cost and quality of care provided to a specific group of Medicare fee-for-service beneficiaries. Providers and suppliers who participate in an ACO still receive traditional Medicare fee-for-service (FFS) payments under Parts A and B. If an ACO meets certain quality and savings criteria, it may receive shared savings payments. In some cases, it may also be required to share in losses if healthcare spending increases.

The changes in this final rule aim to drive growth in participation, particularly in rural and underserved areas, promote equity, advance alignment across accountable care initiatives, and increase the number of beneficiaries assigned to ACOs participating in the program. CMS continues to work to achieve its goal of having 100 percent of people with Original Medicare in a care relationship with accountability for quality and total cost of care by 2030.

Option for Shared Savings Program ACOs to Report Medicare CQMs – p. 840

In light of the concerns raised by ACOs and other stakeholders and CMS’ commitment to supporting ACOs in the transition to digital quality measure reporting, for payment year (PY) 2024 and subsequent PYs, CMS is establishing a new Medicare Clinical Quality Measure (CQM) for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs), as a new collection type for Shared Savings Program ACOs under the Alternative Payment Model (APM) Performance Pathway (APP).

In addition to the new option to report quality data utilizing the Medicare CQMs collection type, in PY 2024, ACOs would have the option to report quality data utilizing the CMS Web Interface measures, eCQMs, and/or MIPS CQMs collection types. In PY 2025 and subsequent PYs, ACOs will have the



option to report quality data utilizing the eQMs, MIPS CQMs, and/or Medicare CQMs collection types.

Data Completeness Standard for Medicare CQMs

CMS established a data completeness criteria threshold of at least 75 percent for the CY 2024, CY 2025, and CY 2026 performance periods for the Medicare CQM collection type, in which a Shared Savings Program ACO that meets the reporting requirements under the APP would submit quality measure data for Medicare CQMs on the APM Entity's applicable beneficiaries eligible for the Medicare CQM, who meet the measure's denominator criteria. This is consistent with the data completeness criteria threshold established for eCQM and MIPS CQM collection types and CMS believes it is appropriate for Medicare CQMs, eCQMs, and MIPS CQMs to have the same data completeness criteria to prevent confusion and complexity and to maintain a level of consistency in the program. CMS is not finalizing its proposal to establish the data completeness criteria threshold of at least 80 percent for the CY 2027 performance period.

Expanding the Health Equity Adjustment to Medicare CQMs

In the CY 2023 PFS final rule, for PY 2023 and subsequent PYs, CMS finalized a health equity adjustment to upwardly adjust the MIPS Quality performance score for ACOs that report eCQMs/MIPS CQMs, are high performing on quality, and serve a higher proportion of underserved beneficiaries.

CMS finalized its proposal to support ACOs in their transition to using all payer/all patient electronic clinical quality measures (eCQMs) and MIPS CQMs. ACOs that report Medicare CQMs would be eligible for a health equity adjustment to their quality performance category score when calculating shared savings payments. For PYs 2024 and beyond, CMS would calculate a health equity adjusted quality performance score for ACOs that report three Medicare CQMs or a combination of eCQMs/MIPS CQMs/Medicare CQMs in the APP measure set. CMS believes that applying the health equity adjustment to an ACO's quality performance category score when reporting Medicare CQMs would encourage ACOs to treat underserved populations.

Changes to APP Measure Set – p. 890

See Table 28 (p. 890) for a summary of the APP reporting requirements and quality performance standard for PY 2024 and subsequent PYs.

See Table 29 (p. 892) for a list of measures included in the final APP measure set that will be reported by Shared Savings Program ACOs for PY 2024 and subsequent PYs.

Modifications to the Health Equity Adjustment Underserved Multiplier – p. 894

The goal of the health equity adjustment is to reward ACOs with high performance scores on quality measures that serve a high proportion of underserved beneficiaries. Correspondingly, the health equity adjustment bonus points are calculated by multiplying the ACO's performance scaler by the ACO's underserved multiplier.

CMS finalized its proposal to revise the underserved multiplier calculation to specify the calculations in more detail and bring greater consistency between the calculation of the proportion of ACOs' assigned beneficiaries residing in a census block group with an area deprivation index (ADI) national



percentile rank of at least 85 and the proportion of ACOs' assigned beneficiaries who are enrolled in Medicare Part D low income subsidy program (LIS) or are dually eligible for Medicare and Medicaid. Specifically, CMS will remove beneficiaries who do not have a numeric national percentile rank available for ADI from the health equity adjustment calculation for PY 2023 and subsequent PYs. Beneficiaries without a national percentile ADI rank would appear neither in the numerator nor in the denominator of the proportion. The agency will continue to assess the impact of using the national ADI in the health equity adjustment in the Shared Savings Program and the use of state ADI in the health equity adjustments used in CMS innovation models and will consider this in future rulemaking.

Use of Historical Data to Establish the 40th Percentile MIPS Quality Performance Category Score – p. 903

CMS will use historical submission-level MIPS Quality performance category scores for PY 2024 and beyond calculated using the 40th percentile MIPS Quality performance category score using a rolling 3-performance year average with a lag of one performance year. CMS will provide ACOs with this performance score before the start of the performance year, enabling them to know the quality performance standard they need to meet. CMS believes this will support ACOs' ability to understand and meet quality goals, allocate resources effectively, and support patients and improve quality outcomes.

Apply a Shared Savings Program Scoring Policy for Excluded APP Measures and APP Measures that Lack a Benchmark – p. 917

CMS will implement a policy to prevent ACOs from being penalized for factors beyond their control, like measure exclusions. For PYs beginning with 2024, if an ACO reports all required measures, meets data completeness requirements, and receives a MIPS Quality score, but their total measure achievement points are reduced due to measure exclusion, CMS will use either the ACO's health equity adjusted quality performance score or the equivalent of the 40th percentile MIPS Quality score to determine if the ACO qualifies for maximum savings under its track for that year. The purpose of this policy is to alleviate the potential adverse impacts to shared savings determinations if one or more of the quality measures required under the APP is excluded.

Align CEHRT Requirements for Shared Savings Program ACOs with MIPS – p. 924

To align the Shared Savings Program with MIPS, CMS proposed to remove the Shared Savings Program CEHRT threshold requirements beginning in PY 2024, and add a new requirement that all MIPS eligible clinicians, Qualifying APM Participants, and Partial QPs participating in the ACO, regardless of track, are to report the MIPS Promoting Interoperability performance category measures and requirements to MIPS at the individual, group, virtual group, or APM level, and earn a MIPS performance category score. Based on the feedback received, the agency will delay implementation of this requirement to performance years beginning on or after January 1, 2025.

Determining Beneficiary Assignment Under the Shared Savings Program – p. 960

CMS is revising the policies for determining beneficiary assignment in the Shared Savings Program. Specifically, CMS plans to (1) use an expanded window for assignment in a new step three to the claims-based assignment process to identify additional beneficiaries for ACO assignment; (2) modify the definition of "assignable beneficiary" to be consistent with this use of an expanded window for



assignment to identify additional beneficiaries to include in the assignable population after application of the existing methodology; and (3) add a new definition of “Expanded window for assignment” to mean the 24-month period used to assign beneficiaries to an ACO, or to identify assignable beneficiaries, or both that includes the applicable 12-month assignment window.

CMS’ changes aim to modify the beneficiary assignment methodology for ACOs to include beneficiaries who receive primary care from nurse practitioners, physician assistants, and clinical nurse specialists, along with those who have received care from physicians in the preceding 12 months. By expanding the assignable population, more beneficiaries from underserved groups, such as those who are disabled, enrolled in Medicare Part D LIS, or reside in areas with higher ADI scores, would be included. This particularly aligns with HHS’ Initiative to Strengthen Primary Care by recognizing the contributions of different clinician types in delivering high-quality primary care.

Comment Solicitation on Potential Future Developments to Shared Savings Program Policies – p.1219

To inform future policy, CMS asked for comments on the following:

- Incorporating a track with a higher risk than the ENHANCED track;
- Modifying the amount of the prior savings adjustment through changes to the 50 percent scaling factor used in determining the adjustment, as well as considerations for potential modifications to the positive regional adjustment to reduce the possibility of inflating the benchmark;
- Potential refinements to the accountable care prospective trend (ACPT) and the three-way blended benchmark update factor, such as (1) replacing the national component of the two-way blend with the ACPT, and (2) scaling the weight given to the ACPT in a two-way blend for each ACO based on the collective market share of multiple ACOs within the ACO’s regional service area; and
- Approaches to promote ACO and CBO collaboration.

CMS will consider stakeholders’ feedback to inform potential future developments to the MSSP.

Updates to the Quality Payment Program (QPP) – p. 1527

CMS continues to move the QPP forward, including a greater focus on measurement efforts and refining how clinicians would be able to participate in a more meaningful way, to achieve continuous improvement in the quality of health care services provided to Medicare beneficiaries and other patients through the QPP’s Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) for the CY 2024 performance period/2026 MIPS payment year.

Transforming the QPP – p. 1546

CMS solicited comments to inform how the agency can modify policies under the QPP to foster clinicians’ continuous performance improvement and positively impact care outcomes for Medicare beneficiaries. CMS is considering stakeholders’ comments and will use it to inform future rulemaking.



Merit-Based Incentive Payment System (MIPS) Value Pathways (MVPs) Development and Maintenance – p. 1548

Highlight: CMS finalized five new MVPs.

In the CY 2023 MPFS final rule, CMS finalized modifications to the MVP development process to include feedback from the public before the notice and comment rulemaking process. CMS aims to gradually develop new MVPs that are relevant and meaningful for all clinicians who participate in MIPS.

As proposed, CMS is finalizing the following five MVPs:

1. Focusing on Women’s Health;
2. Prevention and Treatment of Infectious Disease Including Hepatitis C and HIV;
3. Quality Care in Mental Health and Substance Use Disorder;
4. Quality Care for Ear, Nose, and Throat (ENT); and
5. Rehabilitative Support for Musculoskeletal Care

In the CY 2022 and 2023 PFS final rules, CMS finalized a total of 12 MVPs that became available for reporting as of January 1, 2023. CMS is finalizing modifications to these 12 MVPs to reflect the removal of certain improvement activities and the addition of other relevant existing quality measures.

1. Advancing Rheumatology Patient Care;
2. Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes;
3. Advancing Care for Heart Disease;
4. Optimizing Chronic Disease Management;
5. Adopting Best Practices and Promoting Patient Safety within Emergency Medicine;
6. Improving Care for Lower Extremity Joint Repair; and
7. Patient Safety and Support of Positive Experiences with Anesthesia.
8. Advancing Cancer Care;
9. Optimal Care for Kidney Health;
10. Optimal Care for Neurological Conditions;
11. Supportive Care for Cognitive-Based Neurological Conditions; and
12. Promoting Wellness.

Additionally, through the MVP maintenance process, CMS will consolidate the previously finalized Promoting Wellness and Optimizing Chronic Disease Management MVPs into a single consolidated primary care MVP titled Value in Primary Care MVP. Therefore, for the CY 2024 performance period/2026 MIPS payment year, MVP participants will have a total of 16 MVPs available.

See Appendix 3: MVP Inventory (p. 2641) for details on the new MVPs and modifications to the established MVPs.

MIPS Performance Category Measures and Activities – p. 1571

Highlight: CMS finalized changes to MIPS performance categories (quality, improvement activities, promoting interoperability, and cost) and corresponding measure sets.

There are three MIPS reporting options currently available: Traditional MIPS; MIPS Value Pathways (MVPs); and Alternative Payment Model (APM) Performance Pathway (APP). Under Traditional MIPS and MVPs, performance is measured across four areas – quality, improvement activities,



promoting interoperability, and cost. Alternatively, under APPs, performance is measured across three areas - quality, improvement activities, and promoting interoperability.

Quality Performance Category

CMS finalized the following modifications to the quality performance category:

- To expand the definition of the collection type to include Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs). The addition of Medicare CQMs as a collection type is intended to address some of the data aggregation and patient matching issues Shared Savings Program ACOs experienced when reporting eCQMs and MIPS CQMs under the APP.
- To establish the quality performance category data submission criteria for eCQMs that requires the utilization of CEHRT.
- To establish the data submission criteria for Medicare CQMs.
- To require the administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey in the Spanish translation.
- To maintain the data completeness criteria threshold to at least 75 percent for the CY 2024 and CY 2025 performance periods and/ 2026 and 2027 MIPS payment years.
- To establish the data completeness criteria for Medicare CQMs.

CMS is finalizing a measure set of 198 MIPS quality measures in the inventory for the CY 2024 performance period, which includes the addition of eleven new quality measures, including 1 composite measure and 6 high priority measures, of which 4 are patient-reported outcome measures. (See Appendix A below).

Cost Performance Category

There are currently a total of twenty-five cost measures available: Total per Cost Capita (TPCC) measure; Medicare Spending per Beneficiary (MSBP) Clinician Measure; and 23 episode-based cost measures. In addition to the existing measures, CMS finalized its proposal to add five new episode-based cost measures beginning with the CY 2024 performance period. The measures are:

- An acute inpatient medical condition measure (Psychoses and Related Conditions)
- Three chronic condition measures (Depression, Heart Failure, and Low Back Pain)
- A measure focusing on care provided in the emergency department setting (Emergency Medicine).

CMS finalized the removal of the acute inpatient medical condition measure – Simple Pneumonia with Hospitalization – beginning with the CY 2024 performance period/2026 MIPS payment year. Due to coding changes, the measure no longer assesses the cost of pneumonia-related care as originally intended. Therefore, with these changes there will be a total of twenty-nine cost measures available in the 2024 performance period.

Additionally, CMS finalized its proposal to calculate improvement scoring for the cost performance category at the category level without using statistical significance beginning with the CY 2023 performance period/2025 MIPS payment year. This updated methodology will ensure mathematical and operational feasibility to allow for improvement to be scored in the cost performance category starting with the 2023 performance period/2025 MIPS payment year. This update will also align with CMS' methodology for scoring improvement in the quality performance category.



Improvement Activities Performance Category

CMS is finalizing its proposal to add five new improvement activities. These include an MVP-specific improvement activity titled “Practice-Wide Quality Improvement in MIPS Value Pathways.” This improvement activity would allow clinicians to receive full credit in this performance category for adopting a formal model for quality improvement related to a minimum of three of the measures reported as part of a specific MVP. CMS is also modifying one existing improvement activity and removing three existing improvement activities, leaving a total of 106 improvement activities in the MIPS inventory. A list of the final changes is listed below and included in Appendix 2 (p. 2629) of the final rule.

New Improvement Activities Finalized for the CY 2024 Performance Period/2026 MIPS Payment Year and Future Years

- Improving Practice Capacity for Human Immunodeficiency Virus (HIV) Prevention Services
- Practice-Wide Quality Improvement in MIPS Value Pathways
- Use of Decision Support to Improve Adherence to Cervical Cancer Screening and Management Guidelines (submitted by CDC)
- Behavioral/Mental Health and Substance Use Screening & Referral for Pregnant and Postpartum Women
- Behavioral/Mental Health and Substance Use Screening & Referral for Older Adults

Changes to Previously Adopted Improvement Activities for the CY 2024 Performance Period/2026 MIPS Payment Year and for Future Years

- Use of Decision Support and Standardized Treatment Protocols

Improvement Activities Removed for the CY 2024 Performance Period/2026 MIPS Payment Year and Future Years

- Implementation of co-location PCP and MH services
- Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment [MAT] for Opioid Use Disorder
- Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging

Promoting Interoperability Performance Category

CMS finalized the following changes to the Promoting Interoperability performance category:

- Lengthen the performance period for this category from 90 to 180 days;
- Modify one of the exclusions for the Query of Prescription Drug Monitoring Program (PDMP) measure;
- Provide a technical update to the e-Prescribing measure’s description to ensure it clearly reflects our previously finalized policy; and
- 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.

CMS is also updating the CEHRT definition to align with the Office of the National Coordinator for Health IT (ONC)’s regulations. In a recent proposed rule, ONC signaled a move away from the



“edition” construct for certification criteria. Instead, all certification criteria will be maintained and updated in statute. CMS aims to align with this new definition for QPP and the Medicare Promoting Interoperability Program.

MIPS Final Scoring Methodology – p. 1,535

Highlight: MIPS scoring methodology and category weights remain unchanged from 2023.

For the CY 2024 performance period/2026 MIPS payment year, the scoring weights are unchanged and remain as follows:

- 30 percent for the quality performance category;
- 30 percent for the cost performance category;
- 15 percent for the improvement activities performance category; and
- 25 percent for the Promoting Interoperability performance category.

To avoid a negative adjustment and be eligible for a positive payment adjustment, a provider’s MIPS total score must reach a performance threshold of 82 points for the 2024 MIPS performance period/2026 MIPS payment year, which is the mean of final scores from the 2017 – 2019 MIPS performance periods/2019 – 2021 MIPS payment years.

Public Reporting on Compare Tools – p. 1766

Highlight: CMS finalized proposal to modify existing policy about publicly reporting procedure utilization data on individual clinician profile pages.

CMS finalized its proposal to modify existing policy about identifying telehealth services furnished to inform the public reporting of telehealth indicators on individual clinician profile pages. Instead of using POS and claims modifier codes such as POS code 02, 10, or modifier 95, to identify telehealth services through annual rulemaking, CMS would use the most recent POS and claims modifier codes available as of the time the information is refreshed on clinician profile pages. CMS believes this would give them more flexibility to ensure the accuracy of the telehealth indicator and reduce regulatory burden.

Request for Information: Publicly Reporting Cost Measures – Page 1785

In the proposed rule, CMS included an RFI to evaluate ways to publicly report MIPS eligible clinicians’ performance on measures under the MIPS cost performance category (cost measures). CMS signaled its intent to begin publicly reporting cost measures, beginning with the CY 2024 performance period/2026 MIPS payment year. CMS believes public reporting of these data would assist patients and caregivers in making healthcare decisions and plans to consider the feedback from this RFI in future rulemaking.

Major APM Provisions – p. 1538

Highlight: CMS finalized requirements for APMs to use CEHRT to be an Advanced APM; and QP thresholds are scheduled to increase, consistent with the CAA, 2023.

Advanced APMs

CMS’ current regulations state that 75% of eligible clinicians in each participating APM Entity (for example, an ACO) must be required under the terms of the APM to use CEHRT for the APM to be an Advanced APM. CMS will retain the 75% threshold in CY 2024 and plans to remove the threshold



effective beginning CY 2025. CMS is finalizing its proposal to specify that, to be an Advanced APM, the APM must require the use of certified EHR technology.

APM Incentive

CMS did not finalize its proposal to calculate the qualifying APM participant (QP) determinations at the individual eligible clinician level only, instead of the APM Entity level. Consistent with the CAA, 2023, the QP and Partial QP threshold percentages for the Medicare Option and All-Payer Option will remain unchanged in 2023/2025, as per last year's values. Under current statute, the QP threshold percentages will increase beginning with the 2024 performance year/2026 payment year.

- Medicare payments:
 - QP threshold increasing from 50% to 75%
 - Partial QP threshold increasing from 40% to 50%
- Medicare patients:
 - QP threshold increasing from 35% to 50%
 - Partial QP threshold increasing from 25% to 35%

Under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), clinicians participating in advanced APMs were to receive a 5% incentive payment until the 2022 performance year /2024 payment year. The CAA, 2023, extended the APM Incentive Payment for one year allowing eligible clinicians to receive a 3.5% incentive payment in the 2023 performance year/2025 payment year. After the 2023 performance year/2025 payment year, the APM Incentive Payment will end. As directed under MACRA, beginning for the 2024 performance year/2026 payment year, QPs will receive a higher MPFS update of 0.75% compared to non-QPs, who will receive a 0.25% MPFS update, which will result in a differentially higher PFS payment rate for eligible clinicians who are QPs. Eligible clinicians who are QPs for a year will continue to be excluded from MIPS reporting and payment adjustments for the year.

Appendix A

New Quality Measures Finalized for the CY 2024 Performance Period/2026 MIPS Payment Year and Future Payment Years

- Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood
- Cardiovascular Disease (CVD) Risk Assessment Measure - Proportion of Pregnant/Postpartum Patients that Receive CVD Risk Assessment with a Standardized Instrument
- First Year Standardized Waitlist Ratio (FYSWR)
- Percentage of Prevalent Patients Waitlisted (PPPW) and Percentage of Prevalent Patients Waitlisted in Active Status (aPPPW)



- Preventive Care and Wellness (composite)
- Connection to Community Service Provider
- Appropriate Screening and Plan of Care for Elevated Intraocular Pressure Following Intravitreal or Periocular Steroid Therapy
- Acute Posterior Vitreous Detachment Appropriate Examination and Follow-up
- Acute Posterior Vitreous Detachment and Acute Vitreous Hemorrhage Appropriate Examination and Follow-up
- Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder
- Gains in Patient Activation Measure (PAM®) Scores at 12 Months
- Initiation, Review, And/Or Update to Suicide Safety Plan for Individuals with Suicidal Thoughts, Behavior, Or Suicide Risk
- Reduction in Suicidal Ideation or Behavior Symptoms

Appendix B

New Quality Measures Finalized for the 2025 Performance Period and Future Years

- Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (Clinician Level)

Appendix C

Finalized Changes to Specialty Measure Sets for CY 2024 Performance Period/2026 MIPS Payment Year and Future Payment Years

Endocrinology – Measures Finalized for Addition		
Measure Title and Description	Measure Type	Measure Steward
Connection to Community Service Provider: Percent of patients 18 years or older who screen positive for one or more of the following health-related social needs (HRSNs): food insecurity, housing instability, transportation needs, utility help needs, or interpersonal safety; and had contact with a Community Service Provider (CSP) for at least 1 of their	Process	OCHIN



HRSNs within 60 days after screening.		
Gains in Patient Activation Measure (PAM®) Scores at 12 Months: The Patient Activation Measure® (PAM®) is a 10– or 13– item questionnaire that assesses an individual’s knowledge, skills and confidence for managing their health and health care. The measure assesses individuals on a 0-100 scale that converts to one of four levels of activation, from low (1) to high (4). The PAM® performance measure (PAM®-PM) is the change in score on the PAM® from baseline to follow-up measurement.	Patient-Reported Outcome-Based Performance Measure	Insignia Health, LLC, a wholly owned subsidiary of Phreesia

Endocrinology – Measures Finalized for Removal		
Measure Title and Description	Measure Type	Measure Steward
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan: Percentage of patients aged 18 years and older with a BMI documented during the current encounter or within the previous twelve months AND who had a follow-up plan documented if the most recent BMI was outside of normal parameters.	Process	Centers for Medicare & Medicaid Services



Appendix D



TABLE 118: CY 2024 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
ALLERGY/IMMUNOLOGY	\$217	0%	-1%	0%	-1%
ANESTHESIOLOGY	\$1,650	-2%	-1%	0%	-2%
AUDIOLOGIST	\$69	-1%	-1%	0%	-2%
CARDIAC SURGERY	\$175	-1%	-1%	0%	-2%
CARDIOLOGY	\$6,015	0%	0%	0%	0%
CHIROPRACTIC	\$649	-1%	-1%	0%	-2%
CLINICAL PSYCHOLOGIST	\$717	1%	0%	0%	2%
CLINICAL SOCIAL WORKER	\$801	2%	0%	0%	2%
COLON AND RECTAL SURGERY	\$147	-1%	-1%	0%	-2%
CRITICAL CARE	\$333	-1%	0%	0%	-2%
DERMATOLOGY	\$3,717	0%	0%	0%	-1%
DIAGNOSTIC TESTING FACILITY	\$833	0%	-1%	0%	-2%
EMERGENCY MEDICINE	\$2,473	-2%	-1%	0%	-2%
ENDOCRINOLOGY	\$509	1%	1%	0%	3%
FAMILY PRACTICE	\$5,538	2%	2%	0%	3%
GASTROENTEROLOGY	\$1,476	0%	0%	0%	0%
GENERAL PRACTICE	\$368	1%	1%	0%	2%
GENERAL SURGERY	\$1,625	-1%	-1%	0%	-1%
GERIATRICS	\$184	0%	1%	0%	1%
HAND SURGERY	\$252	-1%	0%	0%	-1%
HEMATOLOGY/ONCOLOGY	\$1,595	1%	0%	0%	2%
INDEPENDENT LABORATORY	\$551	-1%	-1%	0%	-1%
INFECTIOUS DISEASE	\$576	-1%	0%	0%	-1%
INTERNAL MEDICINE	\$9,683	0%	1%	0%	1%
INTERVENTIONAL PAIN MGMT	\$853	0%	0%	0%	0%
INTERVENTIONAL RADIOLOGY	\$458	-1%	-3%	0%	-4%
MULTISPECIALTY CLINIC/OTHER PHYS	\$147	0%	0%	0%	0%
NEPHROLOGY	\$1,813	-1%	0%	0%	-1%
NEUROLOGY	\$1,330	0%	0%	0%	1%
NEUROSURGERY	\$699	-1%	0%	0%	-1%
NUCLEAR MEDICINE	\$51	-1%	-2%	0%	-3%
NURSE ANES / ANES ASST	\$1,081	-2%	0%	0%	-2%
NURSE PRACTITIONER	\$6,297	1%	1%	0%	2%
OBSTETRICS/GYNECOLOGY	\$560	0%	1%	0%	1%
OPHTHALMOLOGY	\$4,647	0%	0%	0%	-1%
OPTOMETRY	\$1,299	-1%	-1%	0%	-2%
ORAL/MAXILLOFACIAL SURGERY	\$63	-1%	-1%	0%	-2%
ORTHOPEDIC SURGERY	\$3,369	-1%	0%	0%	-1%
OTHER	\$56	0%	0%	0%	0%
OTOLARYNGOLOGY	\$1,115	0%	0%	0%	0%
PATHOLOGY	\$1,142	-1%	-1%	0%	-2%
PEDIATRICS	\$56	0%	0%	0%	1%
PHYSICAL MEDICINE	\$1,093	0%	0%	0%	-1%
PHYSICAL/OCCUPATIONAL THERAPY	\$5,281	-1%	-2%	0%	-3%



(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
PHYSICIAN ASSISTANT	\$3,377	1%	1%	0%	2%
PLASTIC SURGERY	\$303	-1%	-1%	0%	-1%
PODIATRY	\$1,910	0%	0%	0%	0%
PORTABLE X-RAY SUPPLIER	\$76	0%	0%	0%	-1%
PSYCHIATRY	\$907	1%	1%	0%	2%
PULMONARY DISEASE	\$1,295	0%	0%	0%	0%
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	\$1,556	0%	-2%	0%	-2%
RADIOLOGY	\$4,536	-1%	-2%	0%	-3%
RHEUMATOLOGY	\$510	1%	1%	0%	2%
THORACIC SURGERY	\$293	-1%	-1%	0%	-2%
UROLOGY	\$1,630	0%	0%	0%	1%
VASCULAR SURGERY	\$1,011	-1%	-3%	0%	-3%
TOTAL	\$88,967	0%	0%	0%	0%

* Column F may not equal the sum of columns C, D, and E due to rounding.