

Vizient Office of Public Policy and Government Relations

Regulatory Update: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program

November 9, 2023

Background & Summary

On November 2, the Centers for Medicare & Medicaid Services (CMS) issued the [Final Rule](#) to update the Calendar Year (CY) 2024 Medicare payment and policies under the Physician Fee Schedule (PFS) (Final Rule). The Final Rule includes changes to physician payment policies, payment rates, and policies under the Medicare Shared Savings Program (MSSP) and Quality Payment Program (QPP)..

In addition to the annual standard payment updates, CMS finalized other policy proposals that will impact hospitals and health systems. This includes the clinical labor update to the practice expense, telehealth policies, payment for preventive vaccine administration services, and changes to the MSSP and QPP. Additional final rule resources include CMS fact sheets on [the final policies](#), the [Medicare Shared Savings Program](#) final policies and the [Quality Payment Program](#) final policies.

The final regulations are effective January 1, 2024, except where noted otherwise.

Major Proposals Finalized & Key Changes from the Proposed Rule

Conversion Factor and Payment Update

CMS finalized their proposed conversion factor of \$32.7476, which is \$1.15 lower than the conversion factor for CY 2023. The payment impact of the proposed policies by specialty is shown in Table 119 of the [Final Rule](#) (pgs. 1955-1957).

Table 1. Final PFS Conversion Factor for CY 2024

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

* CAA, Consolidated Appropriations Act of 2023

Evaluation and Management (E/M) Visits

Add-on Code G2211 (Outpatient/Office E/M Visit Complexity)

In the CY 2021 PFS final rule, CMS provided that HCPCS add-on code G2211 (Outpatient/Office (O/O) E/M visit complexity) could be reported with O/O E/M visits to better account for additional resources associated with primary care or ongoing care related to a patient's single, serious or complex condition. However, the CAA, 2021 imposed a moratorium on Medicare payment for the add-on code until January 1, 2024. CMS finalized policy to allow billing of the G2211 add-on code in CY 2024. Notably, the add-on code cannot be billed with an office or outpatient E/M visit that is focused on a procedure or other service instead of longitudinal care or a single, serious or complex condition. In addition, in the Final Rule, CMS updated their utilization analysis regarding anticipated use of the G2211 add-on code, which, due to budget neutrality requirements, impacts all other CY 2024 payments under the PFS. CMS estimates that the redistributive impact to the CY 2024 conversion factor is nearly one third of the estimated impact from the CY 2021 PFS final rule.

Split (or Shared) Visits

A split (or shared) visit refers to an E/M visit that is performed ("split" or "shared") by both a physician and a non-physician practitioner (NPP) who are in the same group. Since the CY 2022 PFS proposed rule, CMS has considered implementing policy that would alter how split (or shared) visits are billed by using only time spent to determine which practitioner provided the "substantive portion" of the visit.

Since the publication of the CY 2024 proposed rule, the American Medical Association (AMA) CPT Editorial Panel (Panel) released guidelines for CY 2024, specifically addressing the definition of "substantive portion" of a visit. In this new definition, the Panel updated the definition of "substantive portion" to include either 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. CMS finalized policy to adopt this definition of "substantive portion" for split/shared visits for CY 2024.

Telehealth and Remote Patient Monitoring (RPM)

In the Final Rule, CMS implements provisions of the CAA, 2023, which extended a significant number of waivers and flexibilities from the Public Health Emergency (PHE) through December 31, 2024. Two notable clarifications were provided in the final rule.

First, CMS will delay the requirement that distant site practitioners provide their home address on the Medicare enrollment form when providing telehealth services until the end of CY 2024. This is the extension of a waiver from the PHE which was set to expire December 31, 2023. CMS requests further information on how to best enroll distant site practitioners while protecting the safety of the healthcare workforce for future rulemaking.

Second, during the PHE, CMS finalized an interim policy to permit billing for remote monitoring codes which require data collection for at least 16 days in a 30-day period when fewer than 16 days of data are collected within a given 30-day period. In the Proposed Rule, CMS stated that the data collection minimums apply to existing RPM and RTM code families for CY 2024. However, in the Final Rule, CMS clarifies that this policy does not apply to all

Remote Therapeutic Monitoring (RTM) codes, specifically that it does not apply to CPT codes that are treatment management codes that account for time spent in a calendar month.¹

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

For CY 2024, CMS seeks to better recognize how an interdisciplinary team (including community health workers (CHWs)) is involved in treatment of Medicare beneficiaries by updating coding and payment policies to accurately reflect that involvement. Accordingly, CMS finalized three new services to address health-related social needs: Community Health Integration (CHI) Services², Social Determinants of Health (SDOH) Risk Assessments³, and Principal Illness Navigation Services.⁴

RFI: Drugs and Biologicals Which are Not Usually Self-Administered by the Patient, and Complex Drug Administration Coding

The agency received several comments regarding appropriate reimbursement for non-chemotherapeutic complex drug administration coding, urging CMS to provide additional guidance clarifying the conditions under which infusion drugs are considered complex for billing purposes. CMS reiterated that there is existing guidance in the Internet Only Manual (IOM) and that Medicare Administrative Contractors can provide further guidance for which drugs are considered chemotherapy drugs under Medicare. CMS also thanked commenters responding to the self-administered drugs RFI and for identifying critical issues such as appeals, FDA labeling, and accommodating patients who are under a caregiver's care or those that do not have the ability to self-administer drugs. CMS indicated it will consider these comments for future rulemaking.

¹ CPT Codes 99457, 99458, and 98980.

² CMS finalized two new G-Codes describing CHI 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. CHI services address unmet SDOH needs that affect the diagnosis and treatment of the patient's medical problems. CMS also finalized a policy allowing an Annual Wellness Visit (AWV) to serve as a CHI initiating visit, unless the AWV is performed by a type of health care professional who does not have an "incident to" billing benefit for their services under the Medicare program.

³ CMS finalized a policy to establish a stand-alone G-Code for performing an SDOH risk assessment as part of routine patient care in certain visits. The agency notes that assessing SDOH needs is a vital part of patient care and that the resources involved in these activities are not appropriately reflected in current coding. As a result, CMS finalized new standalone G-Code G0136 to increase the frequency of SDOH risk assessments and to promote standardization of such assessments. The assessment may be performed at an Annual Wellness Visit, an E/M visit, or a behavioral health visit. If the risk assessment is performed at the Annual Wellness Visit, Medicare will cover 100% of the cost and the patient will not incur any co-pays. The SDOH Risk Assessment does not need to be performed on the same date as the associated visit. The agency also states its belief that the SDOH Risk Assessment, when used at an E/M or behavioral health visit, will be performed because the practitioner knows or suspects of an SDOH need that interferes with the diagnosis or treatment, and will not be performed prior to the visit. Further, in the case of an initiating visit for CHI or PIN services, the SDOH Risk Assessment code is duplicative, and cannot be billed as part of initiating those services.

⁴ CMS finalized the addition of several new codes for Principal Illness Navigation (PIN) services, when trained or certified auxiliary personnel under the direction of a billing practitioner (which may include a patient navigator or peer specialist) are involved in a patient's health care navigation as part of the treatment plan for a serious, high-risk disease expected to last at least 3 months, that places the patient at significant risk of morbidity or mortality (e.g., cancer, COPD, congestive heart failure, HIV/AIDS, several mental illness, and substance use disorder). The policy includes an expanded list of codes than what was proposed to be more inclusive of the types of auxiliary personnel that could be included in PIN services. CMS reiterates that the list of conditions is not exhaustive, and the agency defers to provider judgment on whether a diagnosis meets the criteria as described in the rule. The AWV as well as certain behavioral health visits may serve as initiating visits for PIN services.

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

In the CY 2023 PFS Final Rule, CMS finalized several policies related to manufacturer refunds for unused and discarded drugs. On the claim form, among other information, if a drug is wasted, the JW modifier is used to indicate waste. Hospital Outpatient Departments (HOPDs) and Ambulatory Surgical Centers (ASCs) are required to report using the JW modifier. The JZ modifier is used when there are no discarded amounts of single-use package drugs (the JZ modifier indicates no waste). In the Final Rule, CMS clarifies that, in the case of self-administered drugs, it is unreasonable to collect information on discarded amounts from a beneficiary. Therefore, the agency finalized the requirements that drugs separately payable under Part B from single-dose containers that are furnished by a supplier who is not administering the drug are to be billed with the JZ modifier.

CMS also discussed the applicability of the JW modifier in Medicare Advantage claims and clarified that the JW modifier requirement does not apply to units billed to Medicare Advantage plans and that the refund amount calculations will not include units billed to Medicare Advantage claims.

Shared Savings Program

Medicare CQMs

For Performance Years (PY) 2024 and beyond, CMS finalized the establishment of Medicare Clinical Quality Measures (CQMs) for Accountable Care Organizations (ACOs) participating in the MSSP as a new collection type for SSP ACOs under the Alternative Payment Model (APM) Performance Pathway (APP). CMS states that this policy will allow the SSP to align with the Universal Foundation of measures for adults in 2025.

Align Certified Electronic Health Record Technology (CEHRT) Requirements

To align the CEHRT requirements for SSP ACOs with Merit-based Incentive Payment System (MIPS) CEHRT requirements, which are more comprehensive, CMS finalized a policy to remove the SSP CEHRT threshold requirements but delayed implementation of the policy until performance years beginning on or after January 1, 2025. Under this policy, all MIPS eligible clinicals, Qualifying APM Practitioners (QPs), and Partial QPs participating in the ACO would report the MIPS Promoting Interoperability (PI) performance category measures and requirements to MIPS, at the individual, group, virtual group, or APM level, and earn a MIPS performance category score.

Modify the Health Equity Adjustment Underserved Multiplier

CMS finalized a change to the calculation of the Health Equity Adjustment underserved multiplier to better account for the number of beneficiaries a clinician treats. This adjustment will use the number of beneficiaries, rather than person years, for calculating the proportion of the ACO's assigned beneficiaries who are enrolled in the low-income subsidy (LIS) program or who are dually eligible for Medicare and Medicaid, starting in PY 2024.

Improve ACO Risk Adjustment and Alignment

Cap Regional Service Area Risk Score Growth for Symmetry with ACO Risk Score Cap

CMS finalized a policy to modify the calculation of the regional component of the three-way blended benchmark update factor⁵ for agreement periods beginning on January 1, 2024. The policy will cap prospective Hierarchical Condition Coding (HCC) risk score growth in an ACO's regional service area between benchmarking year three and the performance year using a similar methodology as the one adopted in the CY 2023 PFS final rule for capping ACO risk score growth. This cap on regional risk score growth would be applied independently of the cap on an ACO's own prospective HCC risk score growth.

Update How Benchmarks are Risk Adjusted

In the [CY 2024 MA Capitation Rates and Part C and Part D Payment Policies final rule](#), CMS finalized the transition to a revised CMS-HCC risk adjustment model (V28). When the CMS-HCC risk adjustment model changes, CMS notes that this complicates SSP performance year and benchmark year comparisons, which tend to negatively impact ACOs with the highest average risk scores, ACOs participating in two-sided models, and ACOs that have been in the SSP longer. To improve consistency in the SSP, CMS finalized a policy to use the same CMS HCC risk adjustment model used in the performance year for all benchmark years when calculating prospective HCC risk scores to risk adjust expenditures used to establish, adjust, and update an ACO's benchmark beginning January 1, 2024. The phase-in will align with the three-year timeline finalized in the Medicare Advantage program, and the underlying performance year 2024 model will be 67% of the current 2020 CMS-HCC risk adjustment model (Version 24) and 33% of V28.

Mitigate the Impact of the Negative Regional Adjustment on the Benchmark to Encourage Participation by ACOs Caring for Medically Complex, High-Cost Beneficiaries

To further incentivize ACO participation, CMS finalized a policy to modify the policies adopted in the CY 2023 PFS final rule to prevent any ACO from receiving an adjustment that would cause its benchmark to be lower than it would have been in the absence of a regional adjustment.⁶

Modifications to Advance Investment Payments (AIP) Policies

CMS finalized policies to allow ACOs to advance to two-sided model levels within the BASIC track's glide path beginning in PY3 of the agreement period in which they receive advance investment payments (AIPs). CMS also finalized a policy to recoup AIPs from shared savings for ACOs that wish to renew to continue their participation in the SSP. CMS indicates it would

⁵ Weighted one-third accountable care prospective trend (ACPT) and two-thirds national-regional blend.

⁶ Under this updated methodology, CMS would continue to calculate the original uncapped regional adjustment, continue to apply the 5 percent cap on positive regional adjustments, and the -1.5 percent cap and offset factor on negative regional adjustments. After these two adjustments, CMS would express the regional adjustment as a single per capita value. If the ACO's regional adjustment amount is positive, the ACO would receive a regional adjustment through the approach finalized in the CY 2023 PFS final rule. If the ACO's regional adjustment is negative, the ACO would receive no regional adjustment to its benchmark for any enrollment type. If the ACO is eligible for a prior savings adjustment, it would receive the prior savings adjustment as its final adjustment.

terminate AIPs for future quarters to ACOs that elect to terminate their participation in the SSP. In addition, CMS will require ACOs to report spend plan updates and actual spend information to CMS in addition to publicly reporting such information. The agency also finalized that ACOs receiving AIPs may seek reconsideration review of all payment calculations. The changes go into effect January 1, 2024.

Updates to the Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established the QPP for eligible clinicians. Under the QPP, MIPS eligible clinicians can participate via one of two tracks – the MIPS (reporting available beginning CY 2023 via traditional MIPS or MIPS Value Pathways (MVPs)) and APMs. Generally, the Final Rule sets forth changes to the QPP starting January 1, 2024. CMS also provides a several resources regarding the Proposed and Final Rules on the [Quality Payment Program website](#).

Traditional MIPS

Traditional MIPS is the original reporting option available for MIPS eligible clinicians. Performance in MIPS is measured across four areas: quality, improvement activities (IA), Promoting Interoperability (PI), and Cost. Often, proposed changes to Traditional MIPS also apply to MVPs. In addition, CMS finalized several policies and provided additional clarity regarding third party intermediaries, including a requirement for third party intermediaries to obtain documentation of their authority to submit on behalf of a MIPS eligible clinician.

Performance Areas

Quality Performance Category

CMS finalized most policies as proposed. However, the agency did not finalize its proposal to increase the data completeness criteria to at least 80 percent for the CY 2027 performance period/2029 MIPS payment year.

CMS also finalized two policies with modifications. First, CMS finalized a policy establishing data completeness criteria for Medicare CQMs to at least 75 percent of the CY 2024, 2025, and 2026 performance periods/2026, 2027, and 2028 MIPS payment years. The agency had proposed to raise the data completeness threshold to 80 percent in the CY 2027 performance period/2029 MIPS payment year. Second, CMS finalized a policy to establish a measure set inventory of 198 MIPS quality measures, down from the proposed 200 measures.

Cost Performance Category

CMS finalized a proposal to add five new episode-based measures to the cost performance category beginning with the CY 2024 performance period/2026 MIPS payment year. These [measures](#) are Depression, Emergency Medicine, Heart Failure, Low Back Pain, and Psychoses and Related Conditions. CMS also finalized a proposal to use a 20-episode case minimum if a MIPS eligible clinician is to be assessed on such a measure. CMS finalized a proposal to remove the Simple Pneumonia with Hospitalization episode-based measure beginning with the CY 2024 performance period/2026 MIPS payment year.

Improvement Activities (IA) Category

CMS finalized the addition of five new IAs, modifications to one existing IA, and removal of three existing IAs⁷ from the inventory for the CY 2024 performance period/2025 MIPS payment year and future years. The five new measures include measures for HIV prevention, cervical cancer screening, behavioral/mental health and substance use screening for pregnant and postpartum women, behavioral/mental health and substance use screening for older adults, and practice-wide quality improvement in the MIPS Value Pathways Program.

Promoting Interoperability Performance Category

CMS finalized all policies as proposed for the PI performance category. These proposals include, among others, lengthening the performance period, modifying the Safety Assurance Factors for Electronic Health Records (SAFER) Guide measure, and providing a technical update to the e-Prescribing measure description.

MIPS Final Scoring Methodology and Scores

Regarding cost, CMS finalized with modifications a proposal to change the cost improvement scoring methodology. Beginning with the FY 2023 performance period/2025 MIPS payment year, CMS finalized policy so that it will determine the cost improvement score at the category-level, instead of the cost-measure level. In addition, CMS finalized policy regarding how it will determine whether sufficient data is available to measure improvement to calculate the cost improvement score. Also beginning with the CY 2023 performance period/2025 payment year, CMS will remove the statistical significance requirement and update the calculation for how CMS quantifies cost improvement scoring. Also, CMS finalized that the maximum cost improvement score is zero percentage points for the CY 2020 through CY 2024 MIPS payment years and one percentage point beginning with CY 2025.

MIPS Payment Adjustments

CMS uses a final score to determine MIPS payment adjustments. In the CY 2024 PFS Proposed Rule, CMS proposed revising the policy for identifying the “prior period” used for establishing the performance threshold. The proposed definition would have defined the “prior period” as three performance periods instead of a single performance period. In the Final Rule, CMS indicates it is not finalizing this policy. As a result, for the CY 2024 performance period/2026 MIPS payment year, CMS will use the CY 2017 performance period/2019 MIPS payment year for establishing the performance threshold. Based on the mean final score from that prior period, the finalized performance threshold is 75 points for the CY 2024 performance period/2026 MIPS payment year.

MIPS Value Pathways (MVPs)

New MVPs and Modifications to Existing MVPs

The agency finalized the addition of five new MVPs to be available within the 2024 performance year. These MVPs are: (1) focusing on women’s health; (2) quality care for the treatment of ear, nose, and throat disorders; (3) prevention and treatment of infectious

⁷ CMS proposes removing the following measures: Implementation of co-location PCP and Mental Health Services; Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging; and Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment for Opioid Use Disorder.

disease including Hepatitis C and HIV; (4) quality care in mental health and substance use disorders; and (5) rehabilitative support for musculoskeletal care.

Subgroup Reporting

CMS finalized changes related to subgroup reporting (the option for clinicians to participate as subgroups for reporting MVPs beginning in the CY 2023 performance period/2025 MIPS payment year). Among other changes, CMS finalized policies to update the subgroup policy for reweighting of MVP performance categories; update the facility-based scoring and complex patient bonus for subgroups under the final score calculation; update the targeted review policy for subgroups; and codify in regulation policies finalized in previous years' rules. Notably, some of the changes would apply retroactively due to operational implementation issues.

APM Performance Pathway (APP)

CMS finalized a policy to include the Medicare CQM for ACOs participating in the MSSP collection type in the APM Performance Pathway (APP) measure set.

CMS finalized a proposal to align the requirements for QP and Partial QP threshold percentages for both the payment amount and patient count methods under the Medicare Option and the All-Payer option with the CAA, 2023 requirements for the 2025 payment year. This new threshold will be 3.5 percent of the eligible clinician's estimated aggregate payments for covered professional services. CMS also finalized adjusting the Targeted Review period to address operational challenges.

CMS did not finalize several proposals, including a proposal to end the use of APM Entity-level QP determinations and instead make all QP determinations at the individual eligible clinician level. In addition, CMS did not finalize a proposal to modify the "sixth criterion" under the definition of "attribution-eligible beneficiary".

Advanced APMs

CMS finalized with modifications a proposal to modify the CEHRT use criterion for Advanced APMs effective CY 2024. CMS will retain the 75 percent CEHRT use minimum for Advanced APMs in CY 2024, and instead remove the threshold beginning in CY 2025. For CY 2025, CMS specifies that the APM must require all APM participants to use CEHRT as redefined in the final rule.

Congress extended the Advanced APM bonus through the CY 2023 performance year in the [CAA, 2023](#). However, if Congress does not act by the end of CY 2023, these payments will expire.

What's Next?

The PFS tables for this CY 2024 Final Rule are available on the [CMS website](#). Most provisions in the Final Rule go into effect January 1, 2024.

Vizient's Office of Public Policy and Government Relations is happy to answer any questions you may have about provisions in this Final Rule. Please direct your feedback to [Emily Jones](#), Regulatory Affairs and Administration Policy Director, in Vizient's Washington, D.C. office.