American College of Radiology

Medicare Physician Fee Schedule Proposed Rule for Calendar Year 2024 Detailed Summary of the Payment and Quality Payment Program Provisions

The American College of Radiology (ACR) has prepared this detailed analysis of proposed changes to the Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2024. The ACR will submit detailed comments to Centers for Medicare and Medicaid Services (CMS) by the September 11th comment period deadline. If finalized, the rule changes will be effective Jan. 1, 2024.

Conversion Factor and CMS Overall Impact Estimates (Page 1191)

CMS estimates a CY 2024 conversion factor (CF) of $32.7476 compared to the 2023 conversion factor of $33.8872. CMS estimates an overall impact of the MPFS proposed changes to radiology to be a 3 percent decrease, while interventional radiology would see an aggregate decrease of 4 percent, nuclear medicine a 3 percent decrease and radiation oncology and radiation therapy centers a 2 percent decrease if the provisions within the proposed rule are finalized. Most of the decrease can be attributed to changes in relative value units (RVUs), the third year of the transition to clinical labor pricing updates, and proposed implementation of the Office/Outpatient (O/O) E/M visit complexity add-on code, G2211.

The specialty impact above from Table 104 in the proposed rule does not take into account the impact of the CAA payment supplements of 2.50 percent for 2023 and 1.25 percent for 2024. These are statutory changes that take place outside of the budget neutrality adjustments. As such, the estimated specialty impact mentioned above will be approximately one to two percent higher.

Appropriate Use Criteria for Advanced Diagnostic Imaging (Page 726)

CMS proposed pausing the Protecting Access to Medicare Act (PAMA) imaging appropriate use criteria (AUC) program due to continued concerns with the real-time claims processing aspect of the statute, stating "…we have exhausted all reasonable options for fully operationalizing the AUC program consistent with the statutory provisions…". The proposal indicated that more time is needed to reevaluate the program to ensure that imaging claims are not inappropriately denied.

Background and Rulemaking History

The rule includes a detailed background of the PAMA imaging AUC program, including an outline of the law and the associated regulations that were developed over the past 8 years. The law requires ordering providers to consult AUC developed by provider-led entities (PLEs) through a clinical decision support mechanism (CDSM) when ordering advanced diagnostic imaging, including CT, MR, PET and nuclear medicine, for Medicare Part B patients. CMS defined PLEs and the process to become a certified PLE in the 2016 rulemaking cycle. The first qualified PLEs were posted on the CMS website in June 2016. The 2017 rulemaking cycle outlined the requirements and process for CDSMs to become qualified. The first qualified CDSMs were posted on the CMS website in July 2017.

In 2018, CMS began a voluntary reporting program for providers who were ready to participate in the ACR program. To incentivize the early use of CDSMs, the agency provided high-weight quality improvement activity credit for ordering professionals who consult AUC using a qualified CDSM for the Merit-based Incentive Payment System (MIPS).

Since 2018, CMS has struggled with operationalizing the portion of the law that requires imaging providers to report AUC consultation information on applicable imaging claims in order to receive reimbursement. If the program were to be fully implemented, payment for imaging services that do not contain the appropriate AUC consultation information on applicable claims would be denied.

Proposal to Pause Program for Reevaluation

The AUC program has been operating in an "educational and operations testing period" without payment penalties in place since January 1, 2020. **CMS proposed to pause the program for reevaluation, including pausing the ongoing educational and operations testing period. In conjunction with this proposal, CMS also proposed to rescind the current AUC program regulations and reserve them for future use. The agency did not propose a time frame for resumption of implementation.** The proposed rule states, "…the real-time claims-based reporting requirement prescribed by section 1834(q)(4)(B) of the Act presents an insurmountable barrier for CMS to fully operationalize the AUC program".

Real-Time Claims-Based Reporting

CMS indicated that the greatest challenge in implementing the imaging AUC program has been operationalizing the real-time claims-based reporting requirement. Despite the development of what the agency believed to be meaningful and workable solutions, there are significant concerns that payment delays and inappropriate claims denials would occur. The existing Medicare claims processing system does not have the capacity to fully automate the process for distinguishing between advanced diagnostic imaging claims that are or are not subject to the AUC program reporting requirements. In addition, CMS stated in the rule, "…reliance on manual reporting by one party of information supplied by another party presents a serious risk to data accuracy and integrity".

Effect on Medicare Beneficiaries

Despite the implementation barriers necessitating the program reevaluation of the program, CMS recognizes the value of the AUC program to improve utilization patterns for Medicare beneficiaries. The Agency indicated that utilizing AUC to ensure that patients receive the right imaging at the right time would "inform more efficient treatment plans and address medical conditions more quickly and without unnecessary tests". The rule states that this could result in potential savings to the Medicare program of $700,000,000 annually. CMS arrived at this estimate by extrapolating savings from a clinical decision support pilot project performed by the Institute for Clinical Systems Improvement in Bloomington, Minnesota.

Nevertheless, CMS is concerned that the real-time claims-based reporting requirement may impact beneficiaries' ability to receive timely imaging services if scheduling is delayed while

imaging providers wait to receive AUC consultation information from reporting providers. In addition, CMS raises the concern of patients being financially liable for advanced diagnostic imaging claims denied by Medicare for failure to include consultation information.

CMS indicated that they will continue efforts to identify workable implementation approaches and will propose to adopt such solutions in future rulemaking. In the meantime, **CMS encourages clinicians to continue to use CDS**.

Summary of Other Quality Initiatives
CMS states, "Promoting the use of AUC in clinical practice is an activity that encourages the use of evidence-based information/guidelines/recommendations to guide patient care thus resulting in improved value and quality.". Subsequent to PAMA, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10, April 16, 2015) established the Quality Payment Program (QPP), which is an incentive program to tie Medicare PFS payment to performance by rewarding high-value, high-quality care. Recognizing the QPP do not specifically target advanced diagnostic imaging services, the agency indicated they believe many of the goals of the AUC program have been met by the QPP and other accountable care initiatives.

MIPS includes 10 specific quality measures pertaining to imaging or under the "Diagnostic Radiology" Specialty Measure Set. Additionally, the Meaningful Measures 2.0 Framework includes a priority area for safety with the goal of "Reduced Preventable Harm" (*https://edit.cms.gov/files/document/cascademeaningful-measures-framework.xlsx*). An objective under this goal is "Diagnostic Accuracy/Error" which includes a cascade measure concept/family of "Appropriate use of radiology and lab testing." An example of an existing measure within this concept is "Appropriate Follow-up Imaging for Incidental Abdominal Lesions" (*https://www.cms.gov/files/document/cascade-measures.xlsx*).

CMS concluded this section of the proposed rule by stating:

> "We want to acknowledge and emphasize the value of clinical decision support to bolster efforts to improve the quality, safety, efficiency and effectiveness of health care. We welcome and encourage the continued voluntary use of AUC and/or clinical decision support tools in a style and manner that most effectively and efficiently fits the needs and workflow of the clinician user. Across many specialties and services, not just advanced diagnostic imaging, clinical decision support predates the enactment of the PAMA and, given its utility when accessed and used appropriately, we expect it to continue being used to streamline and enhance decision making in clinical practice and improve quality of care."

Updates to Prices for Existing Direct Practice Expense Inputs (Page 35)

CMS continues to review and consider invoices they receive for existing direct practice expense (PE) inputs. For CY 2024, many stakeholders submitted invoices for consideration. CMS accepted and updated pricing for 18 supply and equipment items (none affecting Radiology). However, they are not proposing to update the pricing for 11 supply items, mostly due to the availability of the items for cheaper or the submission of only one invoice for common items that may have far-reaching effects across the fee schedule.

CMS continues to welcome the submission of invoices to assist with the pricing of supplies and equipment.

Clinical Labor (CL) Pricing Update (Page 37)

CY 2024 will mark the third year of the clinical labor pricing update phase-in, which will end in 2025. CMS is in the process of updating the pricing for clinical labor staff, in line with recent updates to the supplies and equipment pricing.

CMS relied on data from the Bureau of Labor Statistics (BLS) for most of their clinical staff pricing, but also considered other data from Salary Expert or data provided by stakeholders. CMS continues to welcome input from commenters on appropriate pricing for all clinical staff.

For CY 2024, no new information or wage data was submitted. CMS is moving forward with the pricing finalized in the CY 2023 MPFS.

Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology (Page 44)

CMS has been using the AMA's Physician Practice Information Survey (PPIS) data in its MPFS calculations, including the PE methodology, since 2010. The current PPIS is based on data collected from 2007 and 2008, making it over 15 years old. Even at the time, there were some concerns about gaps in the data its impact on the allocation of indirect PE for certain specialties.

In CY 2023, CMS sought stakeholder feedback on how to improve and update the PE data collection and methodology. They received several comments asking CMS to wait for the AMA to complete a new PPI survey, which they had started working on.

CMS continues to be open to comments and feedback related to their ongoing PE data collection efforts. They want are looking for ways to streamline the process, making it more feasible, easy to update regularly, and to be more transparent and accurate about how the information affections valuations for services paid under the MPFS.

CMS is soliciting comments from stakeholders on the following:

(1) If CMS should consider aggregating data for certain physician specialties to generate indirect allocators so that PE/HR calculations based on PPIS data would be less likely to over-

allocate (or under-allocate) indirect PE to a given set of services, specialties, or practice types. Further, what thresholds or methodological approaches could be employed to establish such aggregations?
(2) Whether aggregations of services, for purposes of assigning PE inputs, represent a fair, stable and accurate means to account for indirect PEs across various specialties or practice types?
(3) If and how CMS should balance factors that influence indirect PE inputs when these factors are likely driven by a difference in geographic location or setting of care, specific to individual practitioners (or practitioner types) versus other specialty/practice-specific characteristics (for example, practice size, patient population served)?
(4) What possible unintended consequences may result if CMS were to act upon the respondents' recommendations for any of highlighted considerations above?
(5) Whether specific types of outliers or non-response bias may require different analytical approaches and methodological adjustments to integrate refreshed data?

Potentially Misvalued Services Under the MPFS (Page 49)

For CY 2024, there were 10 public nominations concerning various codes.

One of the nominations involves CPT code 27279 *(Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device)*. This code currently contains practice expense inputs and pricing in the facility setting only. However, the nominator believes that this procedure can be safely performed in the office/non-facility setting and that allowing payment in the office will increase access for Medicare patients. CMS is concerned about the safety and effectiveness of this procedure being performed in the office setting and is seeking comments on whether CPT code 27279 should be considered potentially misvalued.

Another nomination pertains to the Hospital Inpatient and Observation Care Visit codes 99221 *(Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.)*, 92222 *(Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.)*, and 99223 *(Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.)*, which CMS reviewed in CY 2023. The work RVUs established by CMS for these codes in CY 2023 were a decrease from the work RVUs in CY 2022. The nominator disagreed with the new values, asserting that these codes, which are performed in the non-facility setting, are more intense than other E/M services performed in other settings. The nominator requested that the CY 2022 work RVU for 99221 be reinstated, but requested an increase in value for CPT Codes 99222 and 99223. See Table 6 below.

TABLE 6: A Comparison of Work RVU values for CY 2022, CY 2023, and Those Requested by the Nominator

CPT Code	CY 2022 Work RVU	CY 2023 Work RVU	Requested Work RVU
99221 - 1st hosp ip/obs sf/low 40	1.92	1.63	1.92
99222 - 1st hosp ip/obs moderate 55	2.61	2.60	2.79
99223 - 1st hosp ip/obs high 75v	3.86	3.50	4.25

After consideration, CMS is proposing to maintain the CY 2023 values for these codes, but they are open to further comments.

Valuation of Specific Codes for CY 2024 (Page 145)

Dorsal Sacroiliac Joint Arthrodesis (CPT code 2X000) (Page 145)
CPT code 2X000 *(Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intraarticular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device*)), was created by CPT to replace CPT code 0775T *(Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (eg,bone allograft[s], synthetic device[s]).* CPT codes 27279 *(Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device)* and 27280 *(Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed)* were also flagged for review as part of the code family. However, the RUC agreed with the specialty societies that these codes were clinically different and did not need to be reviewed together. CPT code 27279 was also recently reviewed by the RUC in 2018.

CMS is proposing to accept the RUC's recommended 7.86 work RVUs for CPT code 2X000, as well as the RUC-recommended PE inputs with no refinements.

Fractional Flow Reserve with CT (CPT code 7X005) (Page 158)
In 2018, four new category III codes, 0501T-0504T, were created to describe Fractional Flow Reserve with CT (FFRCT). Medicare began paying for 0503T *(Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software analysis of functional data to assess the severity of coronary artery disease; analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model)* under the Hospital Outpatient Prospective Payment System (HOPPS). Category III codes are typically contractor priced in the MPFS, but an exception was made for FFRCT and CMS has since been trying to understand the resource costs associated with CPT code 0503T in the office setting. CMS, for CY 2022, valued 0503T based on a crosswalk to the technical component of CPT code 93457 *(Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in*

bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization).

CPT code 7X005 *(Noninvasive estimate of coronary fractional flow reserve derived from augmentative software analysis of the data set from a coronary computed tomography angiography, with interpretation and report by a physician or other qualified health care professional)* will replace 0501T-0504T in CY 2024. 7X005 was reviewed by the RUC in January 2023, and a software analysis fee listed as a supply item in the practice expense makes up the majority of its valuation. While CMS acknowledges that there is a cost incurred as part of this procedure, these types of software and analysis fees are not well represented in CMS's current PE methodology and not typically accounted for in the direct PE. Therefore, CMS is proposing to crosswalk the technical component of CPT code 93457 to the technical component for CPT code 7X005.

CMS is proposing the RUC-recommended 0.75 RVU for 7X005 for the professional component. CMS is also proposing to correct the Professional PACS Workstation (ED053) time in the practice expense, from 14.5 minutes to 13.5 minutes.

Ultrasound Guidance for Vascular Access (CPT code 76937) (Page 160)
CPT code 76937 *(Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)* was flagged for review with the peripherally inserted central venous catheter (PICC) codes in January 2018. Since the new PICC codes would now include imaging, utilization for 76937 was expected to decrease, prompting review in October 2022.

CMS is proposing to accept the RUC-recommended 0.30 work RVU for CPT code 76937, as well as the RUC-recommended practice expense inputs with no refinements.

Neuromuscular Ultrasound (CPT codes 76881, 76882, and 76883) (Page 161)
CPT codes 76881 *(Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image documentation),* 76882 *(Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft tissue mass[es]), real-time with image documentation),* and 76883 *(Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity)* were addressed by CMS in the 2023 MPFS. While 76883 was a new code in 2023, CPT codes 76881 and 76882 have been reviewed by the RUC several times. The practice expense inputs for CPT code 76882, specifically, have been under scrutiny, due to frequent shifts in the dominant specialty over the years. In the 2023 MPFS, CMS recommended that the RUC carefully re-review and confirm the PE inputs for this neuromuscular code family based on the latest Medicare claims data.

The RUC reviewed the specialties' updated PE inputs at the recent January 2023 meeting, with only changes recommended for CPT code 76882. CMS is proposing to accept the RUC-recommended PE inputs for 76881 and 76883. CMS is proposing some refinements to the RUC-recommended PE inputs for CPT code 76882, including correcting the Professional PACS Workstation (ED053) time from 13.5 minutes to 17.5 minutes, and maintaining the ultrasound unit, portable (EQ250) time of 15 minutes to be consistent with how this time was allotted for CPT codes 76881 and 76883.

CMS is not proposing any changes to the work RVUs for these codes.

Evaluation and Management (E/M) Visits (Page 240)

Background
CMS, in collaboration with the American Medical Association (AMA) and other stakeholders, has been involved in a multi-year effort to update the coding and payment system for E/M visits in order to better reflect the current practice of medicine, reduce practitioner burnout, be less administratively complex, and ensure accurate reimbursement under the Physician Fee Schedule (PFS).

E/M visits account for around 40% of all allowed charges under the PFS. Office/outpatient (O/O) E/M visits make up approximately half of these charges (around 20% of total PFS allowed charges), while other types of E/M visits (eg, inpatient/observation visits, nursing facility visits, home/residence visits) make up the other half (also around 20% of the total PFS allowed charges). Medicare claims data shows that E/M visits are provided by nearly all specialties, but they represent a larger portion of the total allowed services for physicians and practitioners who do not typically perform procedural interventions or diagnostic tests. Therefore, the policies for revaluation of E/M visits will have a significant impact on relative resource valuation under the PFS.

CMS continues the work to address two outstanding issues in E/M visit payment: implementing separate payment for the O/O E/M visit complexity add-on code for separate payment and define split (or shared) visits.

O/O E/M Visit Complexity Add-on HCPCS code G2211
Starting January 1, 2021, the CPT Editorial Panel, which governs the Current Procedural Terminology (CPT) codes, made changes to the definition of O/O E/M visits. The level of the visit may be selected based on either the time spent on the visit or the level of medical decision-making (MDM) as defined in the CPT E/M Guidelines. The requirement for a history of present illness and a physical exam as elements to determine the visit level has been eliminated. Additionally, the CPT Editorial Panel has updated the time descriptors and guidelines for O/O E/M visits.

CMS has accepted the changes made to the CPT codes and approach for O/O E/M visits. However, they did not accept the revisions for prolonged O/O services. As a result, CMS has created new codes (G2212 and G2211, *Visit complexity inherent to evaluation and management*

associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. [Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established]), specifically for reporting prolonged O/O E/M services and complexity of O/O E/M visits, respectively. It is important to note that Medicare payment for HCPCS code G2211 is prohibited until January 1, 2024, as mandated by the Consolidated Appropriations Act (CCA), 2021. CMS is proposing to change the status of HCPCS code G2211 to make it separately payable by assigning the "active" status indicator, effective January 1, 2024. CMS estimated that the add-on code (G2211) will be billed with 54% of all O/O E/M visits when fully adopted.

CMS is also proposing that the O/O E/M visit complexity add-on code, HCPCS code G2211, would not be payable when the O/O E/M visit is reported with payment modifier-25, *Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service*.

For CY 2023, the CPT Editorial Panel has further revised the remaining E/M visit code families (excluding critical care services) to align them with the framework of O/O E/M visits.

Split (or Shared) Visits
A split (or shared) visit refers to an E/M visit performed by both a physician and a non-physician practitioner (NPP) in the same group practice. In the non-facility (for example, office) setting, the rules for "incident to" billing apply under this circumstance. CMS is proposing to delay the implementation of their definition of the "substantive portion" as more than half of the total time through at least December 31, 2024.

CMS is proposing to maintain the current definition of substantive portion for CY 2024 that allows for use of either one of the three key components (history, exam, or MDM) or more than half of the total time spent to determine who bills the visit.

Adjust RVUs to Match the PE Share of the Medicare Economic Index (MEI) (Page 28)

The Medicare Economic Index (MEI) is a measure of the relative weights of the work RVU, PE RVU, and malpractice (MP) RVU. The MEI is currently based on 2006 AMA data collected from the PPIS, which has not been updated.

In the 2023 MPFS, CMS finalized their plan to revise and rebase the MEI to better reflect current market conditions faced by physicians furnishing physician's services. The 2017-based MEI that CMS finalized relies on annual expense data from the U.S. Census Bureau's services Annual Survey (SAS). However, CMS delayed implementation of the revised and rebased MEI, seeking feedback from stakeholders on how best to incorporate it (full implementation vs. 4-year transition) and maintain payment stability.

CMS is aware that the AMA is working to collect data that could be used to derive cost share weights for the MEI and RVU shares. For CY 2024, CMS is not proposing to move forward with

incorporating the 2017-based MEI at this time. The Agency notes that 2022 SAS data will be available later this year and will continue to monitor that data and any other data that becomes available and will revisit this in future rulemaking.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (Page 86)

As discussed in prior rulemaking, several conditions must be met for Medicare to make payment for telehealth services under the PFS.

Proposed Clarifications and Revisions to the Process for Considering Changes to the Medicare Telehealth Services List

In CY 2020, CMS issued an array of waivers and new flexibilities for Medicare telehealth services to respond to the serious public health threats posed by the spread of COVID-19. Prior to CY 2020, CMS had not added any service to the Medicare Telehealth Services List on a temporary basis. In response to the PHE for COVID-19, CMS revised the criteria for adding or removing services on the Medicare Telehealth Services List using a combination of emergency waiver authority and interim final rule making, so that some services would be available for the duration of the PHE on a "temporary Category 2 basis." In the CY 2021 PFS final rule CMS created a third, temporary category for services included on the Medicare Telehealth Services List on a temporary basis. Services added to the Medicare Telehealth Services List on a temporary, Category 3 basis will ultimately need to meet the Category 1 or 2 criteria to be added to the Medicare Telehealth Services List on a permanent basis.

CMS believes that simplification toward a binary classification approach could address the confusion that CMS has noticed from interested parties submitting requests during the PHE. CMS's proposal would restore the binary that existed with Category 1 and 2, without displacing or disregarding the flexibility of Category 3. CMS is proposing to simply classify and consider additions to the Medicare Telehealth Services List as either permanent, or provisional. Under this new system, CY 2025 submissions would be due by February 10, 2024.

For CY 2024, CMS is proposing to designate any services that are currently on the Medicare Telehealth Services List on a Category 1 or 2 basis and would be on the list for CY 2024 to the proposed new "permanent," category while any services currently added on a "temporary Category 2", or Category 3 basis would be assigned to the "provisional" category.

CMS is soliciting comments on their proposed analysis procedures for additions to, removals from, or changes in status for services on the Medicare Telehealth Services List.

Direct Supervision via Use of Two-way Audio/Video Communications Technology

In the March 31, 2020 COVID-19 IFC, CMS changed the definition of "direct supervision" during the PHE for COVID-19 as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence. CMS states that in the absence of

evidence that patient safety is compromised by virtual direct supervision, CMS believes that an immediate reversion to the pre-PHE definition of direct supervision would prohibit virtual direct supervision, which may present a barrier to access to many services. CMS is proposing to revise the regulatory text to state that, through December 31, 2024, the presence of the physician (or other practitioner) includes virtual presence through audio/video real-time communications technology (excluding audio-only).

CMS is soliciting comments on whether CMS should consider extending the definition of direct supervision to permit virtual presence beyond December 31, 2024. Specifically, CMS is interested in input on potential patient safety or quality concerns when direct supervision occurs virtually; for instance, if virtual direct supervision of certain types of services is more or less likely to present patient safety concerns, or if this flexibility would be more appropriate for certain types of services, or when certain types of auxiliary personnel are performing the supervised service.

Medicare Shared Savings Program (Page 449)

As of January 1, 2023, 10.9 million people with Medicare receive care from one of the 573,126 health care providers in the 456 ACOs participating in the Medicare Shared Savings Program (MSSP). CMS expects there will continue to be an increased number of beneficiaries engaged in ACO's participating in MSSP. In the CY 2021 PFS final rule, CMS finalized modifications to the MSSP quality reporting requirements and quality performance standard for performance year 2021 and subsequent performance years. CMS is proposing changes to the MSSP that CMS hope will advance their overall value-base care strategy of growth, alignment, and equity.

Proposal for Shared Savings Program ACOs to Report Medicare CQMs
CMS is proposing changes to continue to move ACOs toward a digital measurement of quality by establishing a new Medicare Clinical Quality Measure (CQM) collection type for ACOs under the Alternative Payment Model (APM) Performance Pathway (APP).

CMS is proposing updates to the definition of primary care services used for purposes of beneficiary assignment to remain consistent with billing and coding guidelines. Further, CMS is proposing an update that would add a third step to the stepwise beneficiary assignment methodology under which CMS would use an expanded period of time to identify whether a beneficiary has met the requirement for having received a primary care service from a physician who is an ACO professional in the ACO to allow additional beneficiaries to be eligible for assignment. This third step to the stepwise beneficiary assignment proposal will provide greater recognition of the role of nurse practitioners, physician assistants and clinical nurse specialists in delivering primary care services.

Also, CMS is proposing changes to how CMS identify assignable beneficiaries used in certain MSSP calculations. CMS new proposed definition for beneficiary eligible for Medicare CQMs is intended to create alignment with the all payer/all patient MIPS CQM Specifications. CMS

hopes the MSSP proposals improve the incentive for ACOs to sustainably participate and earn shared savings in the program.

Lastly, CMS is seeking comment on potential future developments to MSSP policies, including with respect to incorporating a new track that would offer a higher level of risk and potential reward than currently available under the ENHANCED track, refining the three-way blended benchmark update factor and the prior savings adjustment, and promoting ACO and community-based organization (CBO) collaboration.

Updates to the Quality Payment Program (QPP)

Other Provisions of the Proposed Rule

MIPS Value Pathway (MVP) Reporting for Specialists in Shared Savings Program ACOs - Request for Information (RFI) (p.506)

As previously finalized, ACOs will transition their quality performance reporting to the Alternative Payment Model Pathway (APP) measure set for Medicare Shared Savings Program (MSSP) ACOs. The transition to the APP measure set intends to reduce reporting burden and eliminate differences in how ACOs are scored compared to their MIPS-eligible clinicians. In 2023 MIPS-reporting specialists, including Shared Savings Program ACOs participants, may register to report as either a group, subgroup, or individual. CMS now solicits feedback on scoring incentives that would apply to ACOs' health equity-adjusted performance scores beginning in the performance year 2025, when ACO-participating specialists report quality MVPs. CMS also seeks comments on distributing bonus points for ACOs with MVP reporting specialists. As proposed, ACOs could receive up to ten additional points on their health equity adjusted quality performance score. CMS also includes a request for information regarding multiple aspects of MPV reporting for specialists in MSSP ACOs (p. 509).

Updates to the Quality Payment Program (QPP)

MIPS Value Pathways Development and Maintenance (p. 873)

CMS proposes to include five new MVPs beginning in the 2024 MIPS performance year. Topics include women's health; infectious disease; quality care for ear, nose, and throat; rehabilitative services for musculoskeletal care; and mental health and substance use disorders.

Subgroup Reporting (p. 874)

CMS states that the finalized subgroup reporting policy regarding extreme and uncontrollable circumstances has technical limitations affecting its ability to implement and execute it timely. As such, CMS seeks comments on the timing allowed to adjudicate reconsideration requests for subgroups and their affiliated groups, as the subgroup may not learn of its reweighting status during a significant portion of the relevant performance period, which would undermine its ability to plan data submission needs. They are seeking comments on how to resolve this issue.

Facility-based measurement and scoring policies exclude MVP Participants that are subgroups from facility-based scoring. However, CMS does not intend to calculate facility-based scores at the subgroup level. Therefore, final MIPS scores would not be calculated using the facility-based scores since there isn't an MVP specifically addressing facility-based measurement.

CMS explains that they have identified problems with using claims data associated with subgroup clinicians preventing them from calculating the complex patient bonus at the subgroup level because they cannot determine the beneficiaries seen by subgroup clinicians. Comments are being sought on ways to fix this problem.

MIPS Category Weighting (p. 870)

The proposed category weights for the 2024 performance year are **Quality – 30%, Cost – 30%, Promoting Interoperability (PI) – 25%, and Improvement Activities (IA) – 15%.** These are the same values finalized for the 2022 performance year and are unlikely to change in future years.

The proposed rule continues to offer category reweighting for physicians who are unable to submit data for one or more performance categories. In most cases, the weight of these categories will continue to be redistributed to the Quality category.

MIPS Performance Threshold and Incentive Payments (p. 877)

The MIPS performance threshold is the value that determines whether a MIPS participant will receive a positive, negative, or neutral payment adjustment during the associated MIPS payment year. During the first five years of MIPS, this threshold was set low and incrementally increased each subsequent year to reduce the burden on clinicians and ease them into the program.

During the 2022 and 2023 performance years, CMS set the MIPS performance threshold based on a mean or median value derived from a previous year's scoring data. **Beginning with the 2024 performance year, CMS proposes using the mean of three consecutive years' performance scores starting with 2017-2019 scoring data, which would result in a 2024 performance threshold of 82 points.** This means that clinicians scoring 82 points or higher will receive a neutral or positive payment adjustment, while clinicians falling below 82 points will receive a negative adjustment, **a sizable increase from the 2022-2023 performance threshold of 75 points.**

CMS finalized the minimum and maximum payment adjustment of +/- 9% for performance years 2020 and beyond. No changes are proposed to the MIPS adjustment.

Low-Volume Threshold and Small Practice (15 or fewer eligible clinicians) Considerations (p. 1148)

CMS has not proposed changes to the low-volume threshold criteria. To be excluded from MIPS in 2023, clinicians or groups must meet one of the following three criteria: have ≤ $90K in allowed charges for covered professional services, provide covered care to ≤ 200 beneficiaries,

or provide ≤ 200 covered professional services under the Physician Fee Schedule. CMS proposes retaining the established opt-in policy, allowing physicians who meet some but not all of the low-volume threshold criteria to participate in MIPS.

CMS maintains the six-point small practice bonus included in the Quality performance category score and continues to award small practices three points for submitted quality measures that do not meet case minimum requirements or lack a benchmark. (p. 1256)

Quality Performance Category (p. 904)

CMS has not proposed any major changes to the Quality category. Continuing the scoring policies which went into effect in 2023, the scoring range for benchmarked measures will continue to be 1 to 10 points, and CMS will continue to assign zero points to non-benchmarked measures that have been in the program for three or more years (excluding small practices, who will continue to receive three points). New measures will continue to receive a minimum of seven points in their first year and five points in their second year. **CMS proposes the removal and addition of quality measures as well as a moderate increase in the quality measure data completeness requirement.**

Quality Measures Proposed for Addition and Removal (p. 1515)

CMS proposes removing three measures historically available for reporting through ACR's NRDR QCDR (p. 1517):

- #147: Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
- #324: Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients
- #436: Radiation Consideration for Adult CT: Utilization of Dose Lowering Techniques

Measures 147 and 324 are proposed for removal due to their status as topped out and extremely topped out, respectively. **Measure 436 is proposed for removal as it is considered duplicative of the new measure which is proposed for addition in the Diagnostic Radiology measure set:**

- #TBD: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults (p. 1515)

Notably, this new Diagnostic Radiology measure is proposed as an eCQM, which means it would not be reportable as a traditional MIPS CQM. See below for details about this newly proposed measure:

- **Description:** This measure provides a standardized method for monitoring the performance of diagnostic CT to discourage unnecessarily high radiation doses, a risk

factor for cancer, while preserving image quality. It is expressed as a percentage of CT exams that are out-of-range based on having either excessive radiation dose or inadequate image quality relative to evidence-based thresholds based on the clinical indication for the exam. All diagnostic CT exams of specified anatomic sites performed in inpatient, outpatient and ambulatory care settings are eligible. This eCQM requires the use of additional software to access primary data elements stored within radiology electronic health records and translate them into data elements that can be ingested by this eCQM.

- **Denominator:** All CT scans in adults aged 18 years and older at the start of the measurement period that have a CT Dose and Image Quality Category and were performed during the measurement period.
- **Numerator:** Calculated CT size-adjusted dose greater than or equal to a threshold specific to the CT dose and Image Quality Category, or Calculated CT Global Noise value greater than or equal to a threshold specific to the CT Dose and Image Quality Category. (p. 1437)

Quality Data Completeness Requirements (p. 875)

CMS signaled in the 2023 MPFS final rule that they intend to raise the quality measure data completeness requirement to 75% for the 2024 and 2025 performance periods. This number defines the minimum subset of patients within a measure denominator that must be reported. **CMS also proposes increasing this threshold to 80% beginning with the 2026 performance year.**

Cost Performance Category (p. 875)

CMS proposes reintroducing the episode-based Low Back Pain cost measure previously used in the MIPS Cost category. The measure underwent comprehensive reevaluation and field testing from 2020-2022. Stakeholder input and workgroup review were used to obtain detailed information on specifications for the measure. The ACR participated in the review. CMS also proposes adding Depression, Emergency Medicine, Heart Failure, and Psychoses and Related Conditions as new episode-based Cost measures for 2024.

The Cost category will remain weighted at 30% for 2024.

Improvement Activities Performance Category (p. 1106)

CMS has not proposed any major changes to the Improvement Activities performance category. This category will remain weighted at 15% as in previous years. CMS proposes adding five new activities and remove three previously adopted activities.

Table 1. Improvement Activities Proposed for Adoption.

Improvement Activity Title	Description	Category Weight
Improving practice capacity for Human	Establish policies and procedures to improve practice capacity to increase HIV prevention	Medium

Immunodeficiency Virus (HIV) prevention services	screening, improve HIV prevention education and awareness, and reduce disparities in pre-exposure prophylaxis (PrEP) uptake. Use one or more of the following activities: • Implement electronic health record (EHR) prompts or clinical decision support tools to increase appropriate HIV prevention screening; • Require that providers and designated clinical staff take part in at least one educational opportunity that includes components on the importance and application of HIV prevention screening and PrEP initiation in clinical practice; and/or • Assess and refine current policies for HIV prevention screening, including integrated sexually transmitted infection (STI)/HIV testing processes, universal HIV screening, and PrEP initiation.	
Practice-Wide Quality Improvement in MIPS Value Pathways	Create a quality improvement initiative within your practice and create a culture in which all staff actively participates. Clinicians must be participating in MIPS Value Pathways (MVPs) to attest to this activity. Create a quality improvement plan that involves a minimum of three of the measures within a specific MVP and that is characterized by the following: • Train all staff in quality improvement methods, particularly as related to other quality initiatives currently underway in the practice; • Promote transparency and accelerate improvement by sharing practice-level and panel-level quality of care and patient experience and utilization data with staff; • Integrate practice change/quality improvement into all staff duties, including communication and education regarding all current quality initiatives; • Designate regular team meetings to review data and plan improvement cycles with defined, iterative goals as appropriate; or • Promote transparency and engage patients and families by sharing practice-level quality of care and patient experience and utilization data with patients and families, including activities in which clinicians act upon patient experience data.	High

	In addition, clinicians may consider: • Creation of specific plans for recognition of individual or groups of clinicians and staff when they meet certain practice-defined quality goals. Examples include recognition for achieving success in measure reporting and/or a high level of effort directed to quality improvement and practice standardization; and • Participation in the American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program.	
Use of Computable Guidelines and Clinical Decision Support to Improve Adherence for Cervical Cancer Screening and Management Guidelines	Incorporate the Cervical Cancer Screening and Management (CCSM) Clinical Decision Support (CDS) tool within the electronic health record (EHR) system to provide clinicians with ready access to and assisted interpretation of the most up-to-date clinical practice guidelines in CCSM to ensure adequate screening, timely follow-up, and optimal patient care. The CCSM CDS helps ensure that patient populations receive adequate screening and management, according to evidence-based recommendations in the United States Preventive Services Task Force (USPSTF) screening and American Society for Colposcopy and Cervical Pathology (ASCCP) management guidelines for cervical cancer. The CDS integrates into the clinical workflow a clinician-facing dashboard to support the clinician's awareness and adoption of and preventive care for cervical cancer, including screening and any necessary follow-up treatment. The CCSM CDS is fully conformant with the HL7 Fast Healthcare Interoperability Resources (FHIR) standard, so it can be used with any certified EHR platform. The CDS Hooks and SMART-on-FHIR interoperability interface standards provide two ways to integrate with the clinical workflow in a way that complements existing displays and information pre-visit, during visit, and for post-visit follow-up. CCSM CDS helps the clinician evaluate the patient's clinical data against existing guidance and displays patient-specific recommendations.	High

Behavioral/Mental Health and Substance Use Screening & Referral for Pregnant and Postpartum Women	Screen for perinatal mood and anxiety disorders (PMADs) and substance use disorder (SUD) in pregnant and postpartum women, and screen and refer to treatment and/or refer to appropriate social services, and document this in-patient care plans.	High
Behavioral/Mental Health and Substance Use Screening & Referral for Older Adults	Complete age-appropriate screening for mental health and substance use in older adults, as well as screening and referral to treatment and/or referral to appropriate social services, and document this in-patient care plans.	High

Table 2. Improvement Activities Proposed for Removal.

Improvement Activity Title	CMS' Rationale
IA_BMH_6: Implementation of co-location PCP and MH services	We propose to remove this activity under removal factor two, there is an alternative activity with a stronger relationship to quality care or improvements in clinical practice, and factor three, activity does not align with current clinical guidelines or practice. We have received interested-party feedback expressing concern that this activity is out-of-date, and that IA_BMH_6 substantially overlaps with IA_BMH_7 (Implementation of Integrated Patient Centered Behavioral Health Model). IA_BMH_7 better aligns with evidence supporting improved patient outcomes. Furthermore, IA_BMH_6 focuses on co-location of mental health and substance use disorder services in primary and/or nonprimary clinical care settings, which has not been found to consistently improve patient outcomes. In the current rulemaking cycle, we are proposing two new activities in the Behavioral and Mental Health subcategory. We note that the removal of IA_BMH_6 is being proposed in order to ensure that the improvement activities Inventory best reflects current clinical practice, and in no way reflects a de-emphasis of the ongoing priority CMS is placing on behavioral and mental health in general, and on substance use disorder in particular.
IA_BMH_13: Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment for Opioid Use Disorder	We propose to remove this activity under removal factor three, activity does not align with current clinical guidelines or practice. In late December 2022, the end of the "X-waiver" was announced, so doctors/nurse practitioners no longer need to complete training and obtain a waiver from the Drug Enforcement

	Administration (DEA) to be able to prescribe buprenorphine (medication-assisted treatment; MAT). Section 1262 of the Consolidated Appropriations Act of 2023 (also referred to as the "Omnibus Bill") was passed in December 2022. We note that the removal of IA_BMH_13 is being proposed in order to ensure that the improvement activities Inventory best reflects current clinical practice, and in no way reflects a de-emphasis of the ongoing priority CMS is placing on behavioral and mental health in general, and on substance use disorder in particular. This removal is necessary as the X-waiver is no longer a requirement of MAT prescribing.
IA_PSPA_29: Consulting Appropriate Use Criteria (AUC) Using Clinical Decision Support when Ordering Advanced Diagnostic Imaging	We propose to remove this activity under removal factor seven, improvement activity is "obsolete." The AUC CDS program has ended, so it will no longer be possible to attest to this activity.

Promoting Interoperability Performance Category (p. 876)

CMS proposes to modify Certified EHR Technology (CEHRT)-related requirements to remove "Edition" title references. This change would reflect a recent proposal from the HHS Office of the National Coordinator for Health IT (ONC) to update individual health IT certification criteria and standards instead of implementing new editions, or complete sets, of certification criteria. As a result, future updates to specific ONC certification criteria under 45 CFR 170.315 incorporated by reference into CMS' "CEHRT" definition would be automatically accounted for without needing further rulemaking by CMS. The agency also proposes to align CEHRT definition requirements in the Shared Savings Program with that used in MIPS.

Most radiologists will continue to be exempted from Promoting Interoperability and automatically reweighted. However, for any eligible clinicians participating in the MIPS Promoting Interoperability category, CMS proposes to lengthen the performance period from 90 days to 180 days. CMS proposes to change the "Safety Assurance Factors for EHR Resilience (SAFER) Guides" measure to require a "yes" attestation for completion, rather than allowing

either "yes" or "no." Additionally, CMS proposes to modify the measure exclusion for "Query of Prescription Drug Monitoring Program" to accommodate clinicians who do not prescribe Schedule II opioids and Schedule III and IV drugs during the performance period.

APM Performance Pathway

CMS is proposing to include the Medicare Clinical Quality Measure (Medicare CQM) for Accountable Care Organizations Participating in MSSP collection type in the APM Performance Pathway (APP) measure set.

Advanced Alternative Payment Models

An Advanced APM is an APM that: 1) requires participants to use certified EHR technology (CEHRT), 2) provides payment for covered services based on quality measures comparable to MIPS, and 3) requires participating entities to bear more than nominal financial risk or participate as a Medical Home Model.

Use of Certified Electronic Health Record Technology (CEHRT)
Additionally, CMS is proposing to remove the numerical 75% threshold and specify that, to be an Advanced APM, the APM must require the use of certified EHR technology. This means EHR technology certified under the ONC Health IT Certification Program that meets: (1) the 2015 Edition Base EHR definition, or any subsequent Base EHR definition (as defined in at 45 CFR 170.102); and (2) any such ONC health IT certification criteria adopted or updated in 45 CFR 170.315 that are determined applicable for the APM, for the year, considering factors such as clinical practice areas involved, promotion of interoperability, relevance to reporting on applicable quality measures, clinical care delivery objectives of the APM, or any other factor relevant to documenting and communicating clinical care to patients or their health care providers in the APM.

APM Incentives
CMS is proposing to end the use of APM Entity-level QP determinations and instead make all QP determinations at the individual eligible clinician level. CMS is proposing to include any beneficiary who has received a covered professional service furnished by the NPI for the purpose of making QP determinations.

Also, CMS is proposing to amend § 414.1430 to reflect the statutory 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 respect to payment year 2025 (performance year 2023) in accordance with amendments made by the CAA, 2023. Based on the CAA, 2023 the APM Incentive Payment with respect to payment year 2025 is 3.5% of the clinician's estimated aggregate payments for covered professional services during the incentive payment base period. After the 2023 performance year/2025 payment year, the APM Incentive Payment will end. Beginning for the 2024 performance year/2026 payment year, QPs will receive a higher PFS update "qualifying APM conversion factor" of 0.75% compared to non-QPs, who will receive a 0.25% PFS 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.

ACR staff continue to further analyze the proposed rule and will be submitting comments to CMS by the September 11th deadline.