Issue Brief

FEDERAL ISSUE BRIEF

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CMS Issuing CY 2024 Medicare Payment Corrections Under the Physician Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) are issuing an 18-page correction notice to the Final Calendar Year (CY) 2024 Medicare and Medicaid Payment Policies Under the Physician Fee Schedule (PFS) 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.

The document is currently available at: https://public-inspection.federalregister.gov/2024-02705.pdf. The notice is scheduled for publication on February 12. The changes are retroactive to January 1, 2024.

Comment
CMS refers to the actual published version of the CY 2024 PFS final rule. The rule is available at: https://www.govinfo.gov/content/pkg/FR-2023-11-16/pdf/2023-24184.pdf.

This is the second rule from CMS this week regarding corrections to CY 2024 payment systems. First the OPPS/ASC and now the PFS. This rule's format is similar to the OPPS/ASC notice. However, the rule appears to make the corrections much easier to follow.

We have excerpted sections of the final rule that are being changed/ corrected to assist the reader in understanding the items being changed. Any comments in the excerpted ***Federal Register*** sections saying "We" refers to CMS.

The rule's major heads include;

I. Background
II. Summary of Errors
III. Waiver of Proposed Rulemaking and Delay in Effective Date
IV. Correction of Errors

A. Correction of Errors in the Preamble

1. On page 78867, the table titled "TABLE 11: CY 2024 Medicare Telehealth Services List", the table is corrected to insert the following additional rows after the row for HCPCS code 0373T:

HCPCS	Short Descriptor	Audio-Only?	Category
0591T	Hlth&wb coaching indiv 1st	Yes	provisional
0592T	Hlth&wb coaching indiv f-up	Yes	provisional
0593T	Hlth&wb coaching indiv group	Yes	provisional
77427	Radiation tx management x5	No	provisional

2. On page 78876, second column, fourth full paragraph,
   a. Line 2, the phrase "telehealth services" is corrected to read "DSMT and therapy telehealth services".
   b. Line 6, the language "modifier `95.'" is corrected to read "modifier `95.' For further background, we refer readers to pgs. 44-45, 80-81 of our FAQ available at https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf."

3. On page 78918, third column, second full paragraph, second sentence that reads "If caregivers are trained in a group, practitioners would not bill individually for each caregiver" is corrected to read: "If caregivers for the same beneficiary are trained in a group, practitioners would not bill individually for each caregiver".
4. On page 78920, first column, first full paragraph, line 9, that reads "a median group size of five caregivers" is corrected to read "a median group size of caregivers for five beneficiaries".
5. On page 78944, first column, first full paragraph for code G0023, lines 5 and 6, the phrase "certified peer specialist" is deleted.
6. On page 78949, first column, first full paragraph, line 3 that reads "services can be provided more than" is corrected to read "services cannot be provided more than".
7. Beginning on page 78956, in the last row and continuing on page 78957, in the table titled, "TABLE 14: CY 2024 Work RVUs for New, Revised, and Potentially Misvalued Codes", the entry for HCPCS code G0019 is replaced in its entirety with the following:

G0019	Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting the ability to diagnose or treat problem(s) addressed in an initiating visit: • Person-centered assessment, performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating visit. ++ Conducting a person-centered assessment to understand patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not separately billed). ++ Facilitating patient-driven goalsetting and establishing an action plan. ++ Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan. • Practitioner, Home-, and Community-Based Care Coordination ++ Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable). ++ Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors. ++ Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities. ++ Facilitating access to community based social services (e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s). • Health education—Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the SDOH need(s), and educating the patient on how to best participate in medical decision making. • Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment. • Health care access/health system navigation ++ Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.				

	• Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals. • Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals. • Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.				

8. Beginning on page 78958, in the second and third rows and continuing on page 78959,in the table titled, "TABLE 14: CY 2024 Work RVUs for New, Revised, and Potentially Misvalued Codes", the entries for HCPCS codes G0022 and G0023 are replaced in their entirety with the following:

G0022	Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019).	NEW	0.70	0.70	NO
G0023	"Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities: • Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition. ++ Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that are not separately billed). ++ Facilitating patient-driven goal setting and establishing an action plan. ++ Providing tailored support as needed to accomplish the practitioner's treatment plan. • Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services. • Practitioner, Home, and Community-Based Care Coordination. ++ Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable). ++ Communication with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors. ++ Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities. ++ Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s). • Health education—Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making. • Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition. • Health care access/health system navigation. ++ Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them.	NEW	1.00	1.00	NO

	++ Providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable. • Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals. • Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals. • Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, membership, or inspiration to meet treatment goals."				

9. Beginning on page 78959, in the last row and continuing on page 78960, in the table titled, "TABLE 14: CY 2024 Work RVUs for New, Revised, and Potentially Misvalued Codes", the entry for HCPCS code G0140 is replaced in its entirety with the following:

G0140	Principal Illness Navigation—Peer Support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities: • Person-centered interview, performed to better understand the individual context of the serious, high-risk condition. ++ Conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet SDOH needs (that are not billed separately). ++ Facilitating patient-driven goal setting and establishing an action plan. ++ Providing tailored support as needed to accomplish the person centered goals in the practitioner's treatment plan. • Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services. • Practitioner, Home, and Community-Based Care Communication ++ Assist the patient in communicating with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors. ++ Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s). • Health education—Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making. • Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition. • Developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals. • Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet person-centered diagnosis and treatment goals. • Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.	NEW	1.00	1.00	NO

10. On page 78975, first column, first full paragraph, line 26, the phrase that reads "this policy is implemented." is corrected to read, "this policy is implemented. CMS is finalizing as proposed that payment will not be made for the inherent complexity add-on code (G2211) when billed with an O/O E/M service reported with modifier -25."

11. On page 79075, third column, first full paragraph, line 19 that reads "G0022, G0023, and G0024 respectively" is corrected to read "G0022, G0023, G0024, G0140 and G0146, respectively."

12. On page 79112, in the table titled, "TABLE 28: Final APP Reporting Requirements and Quality Performance Standard for Performance Year 2024 and Subsequent Performance Years", second column, third row, second paragraph, lines 4 through 6, the phrase that reads "and receives a MIPS Quality performance category score under § 414.1380(b)(1)" is removed.

13. On page 79112, in the table titled "TABLE 28: Final APP Reporting Requirements and Quality Performance Standard for Performance Year 2024 and Subsequent Performance Years", second column, third row, third paragraph, line 6, the phrase that reads "in the APP measure would" is corrected to read "in the APP measure set would".

14. On page 79113, in the table titled "TABLE 29: Measures included in the APP Measure Set for Performance Year 2024 and Subsequent Performance Years", sixth column, second row, the identifier "PRO-PM*" is corrected to read "Patient Engagement/Experience". The related footnote "* Patient-reported outcome-based performance measure (PRO-PM) is a performance measure that is based on patient-reported outcome measure (PROM) data aggregated for an accountable healthcare entity." is removed.

15. On page 79121, third column, lines 4 through 6, the sentence that reads "We note that Table 30 is same as Table 29 that was included in the CY 2024 PFS proposed rule (88 FR 52432)." is removed.

16. On page 79121, in the table titled "TABLE 30: 40th Percentile MIPS Quality Performance Category Scores Using Current and Finalized Methodology", that reads:

TABLE 30: 40th Percentile MIPS Quality Performance Category Scores Using Current and Finalized Methodology

Performance Year	**Actual 40th percentile MIPS Quality performance category score***	**40th percentile MIPS Quality performance category score using historical methodology**
2018	70.80*	--
2019	70.82*	--
2020	75.59*	--
2021	77.83*	--
2022	72.40 (Estimated for illustrative purposes)**	

is corrected to read:

TABLE 30: 40th Percentile MIPS Quality Performance Category Scores Using Current and Finalized Methodology

Performance Year	Actual 40th percentile MIPS Quality performance category score*	40th percentile MIPS Quality performance category score using historical methodology
2018	70.80*	--
2019	70.82*	--
2020	75.59*	--
2021	77.83*	--
2022	77.73^	72.40 (Estimated for illustrative purposes)**

17. On page 79131, second column, second full paragraph, first bullet, line 5 that reads "subpart Oat the individual, group," is corrected to read "subpart O at the individual, group,".

18. On page 79144, third column, line 23, the reference that reads "section VI.E." is corrected to read "section VII.E.".

19. On page 79172, third column, second full paragraph, lines 10 through 14, that reads "furnished by an ACO professional who is a physician (as defined in section 1861(r)(1)) of the Act), or a practitioner that is a PA, NP, CNS (as defined in section 1842(b)(18)(C)(i) of the Act)." is corrected to read "furnished by an ACO professional who is a physician."

20. On page 79189:

a. The third column, first full paragraph, line 1 the phrase that reads "Tables 41 and 42" is corrected to read "Tables 42 and 43".
b. The third column, first full paragraph, line 8, the phrase that reads "Tables 39 and 40" is corrected to read "Tables 40 and 41".

21. On page 79240, the first column, first paragraph, lines 8 and 9 the phrase that reads "as displayed in Tables 46A and 46B" is deleted.

22. On page 79379, in the table titled "TABLE 60: Illustration of Point System and Associated Adjustments Comparison between the CY 2023 Performance Period/2025 MIPS Payment Year and the CY 2024 Performance Period/2026 MIPS Payment Year":

a. Second column, fourth row, line 3 that reads "sliding scale ranges from 0 to 9% for scores from 75.00 to 100.00" is corrected to read "sliding scale ranges from greater than 0% to 9% for scores from 75.01 to 100.00."; and
b. Fourth column, fourth row, line 3 that reads "linear sliding scale ranges from 0 to 9% for scores from 86.00 to 100.00" is corrected to read "linear sliding scale ranges from greater than 0% to 9% for scores from 75.01 to 100.00.".

23. On page 79437, in the table titled "TABLE 83: Summary of Quality Measure Inventory Finalized for the CY 2024 Performance Period", fifth column, row 4, that reads:

Collection Type	# Measures as New	# Measures for Removal*	# Measures with a Substantive Change*	# Measures for CY 2024*
eCQM Specifications	0	-3	26	44

is corrected to read;

Collection Type	# Measures as New	# Measures for Removal*	# Measures with a Substantive Change*	# Measures for CY 2024*
eCQM Specifications	0	-3	26	46

24. On page 79467, in the table titled "TABLE 116: Calculation of the CY 2024 PFS Conversion Factor", that reads:

CY 2023 Conversion Factor		33.8872
Conversion Factor without the CAA, 2023 (2.5 Percent Increase for CY 2023)		33.0607
CY 2024 RVU Budget Neutrality Adjustment	-2.20 percent (0.9780)	
CY 2024 1.25 Percent Increase Provided by the CAA, 2023	1.25 percent (1.0125)	
CY 2024 Conversion Factor		**32.7375**

is corrected to read;

CY 2023 Conversion Factor		33.8872
Conversion Factor without the CAA, 2023 (2.5 Percent Increase for CY 2023)		33.0607
CY 2024 RVU Budget Neutrality Adjustment	-2.18 percent (0.9782)	
CY 2024 1.25 Percent Increase Provided by the CAA, 2023	1.25 percent (1.0125)	
CY 2024 Conversion Factor		**32.7422**

25. On page 79506, in the table titled "TABLE 131: Description of MIPS Eligibility Status for CY 2023 Performance Period/2025 MIPS Payment Year Using CY 2023 PFS Final Rule Assumptions", the title of the table is corrected to read "TABLE 131: Description of MIPS Eligibility Status for CY 2024 Performance Period/2026 MIPS Payment Year Using CY 2023 PFS Final Rule Assumptions".

26. On page 79506, in the table titled "TABLE 131: Description of MIPS Eligibility Status for CY 2023 Performance Period/2025 MIPS Payment Year Using CY 2023 PFS Final Rule Assumptions", the first and second footnotes which read: "*Participation excludes facility-based clinicians who do not have scores in the 2021 MIPS submission data. **Allowed charges estimated in 2021 dollars. Low-volume threshold is calculated using allowed charges. MIPS payment adjustments are applied to the paid amount."

are corrected to read:

"*Participation excludes facility-based clinicians who do not have scores in 2022 MIPS submission data **Allowed charges estimated in 2022 dollars. Low-volume threshold is calculated using allowed charges. MIPS payment adjustments are applied to the paid amount."

27. On page 79519, third column, first full paragraph, line 7, the phrase that reads "2025 MIPS payment year." is corrected to read "2026 MIPS payment year."

28. On page 79522, in the table titled "TABLE 143: Accounting Statement for Provisions for Medicare Shared Savings Program (CYs 2024-2033)", fifth column, third and fourth full rows, the phrase that reads "Tables 120 through 123" is corrected to read "Tables 123 through 126".

B. Correction of Errors in the Addenda

29. On page 79939 of APPENDIX 1: MIPS QUALITY MEASURES, TABLE D.45: One-Time Screening for Hepatitis C Virus (HCV) for all Patients, row 6, Substantive Change: in the section titled: Updated denominator: Updated:

THERE ARE TWO SUBMISSION CRITERIA FOR THIS MEASURE:

First full paragraph, lines 6 through 8 that read: "For accountability reporting in the CMS MIPS program, the rate for submission criteria 2 is used for performance, however, both performance rates must be submitted." is to be removed.

30. On page 80015 of APPENDIX 3: MVP INVENTORY, TABLE B.2: Optimal Care for Kidney Health MVP language in the last paragraph of the Comments and Responses section should read: "After consideration of public comments, we are finalizing the Optimal Care for Kidney Health MVP with modifications in Table B.2 for the CY 2024 performance period/2026 MIPS payment year and future years."

31. On pages 80013, 80016, and 80026 of APPENDIX 3: MVP INVENTORY, corresponding to TABLE B.2: Optimal Care for Kidney Health MVP, TABLE B.3: Optimal Care for Patients with Episodic Neurological Conditions MVP, and TABLE B.6: Advancing Rheumatology Patient Care MVP, respectively, the Collection Type for measure Q130 is corrected by removing "Medicare Part B Claims Measure Specifications" and reads " eCQM Specifications, MIPS CQMs Specifications)".

Comment
This notice is well written and easy to follow. Kudos to CMS for providing sufficient information from the November 16, 2023 rule in explaining the corrections being made.

The one that will impact all providers is #24 above regarding the change to the 2024 conversion factor.