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Quality Payment Program

Make sure the MVP fits your clinicians, run traditional MIPS as a backup

Participation in the Merit-Based Incentive Payment System Value Pathway (MVP) program gives providers another opportunity to meet their quality payment participation goals this year ([PBN 7/31/23](#)).

The program creates subsets of “measures and activities that are related to a given specialty or medical condition,” according to the Quality Payment Program (QPP) website. The subsets are similar to the specialty measures sets, but they also include pre-selected Improvement Activities and Promoting Interoperability measures.

Practices can test the MVP program while running a traditional quality payment program to boost their chances of success, according to CMS officials who participated in the 2023 MVPs Overview & Office Hours Webinar on July 31. During the call, CMS officials emphasized the importance of making sure the MVP is a good fit for providers who want to participate.

CMS also made it clear that the MVP will be optional for the foreseeable future. “We have not set a date ... to sunset traditional MIPS. That would be done through notice of comment rulemaking,” said Sophia Sugumar, a health insurance specialist with CMS, in response to a question by a webinar attendee.

You have a dozen to choose from

CMS has created 12 MVPs for the 2023 reporting year. Some MVPs could apply to several specialties, such as the Promoting Wellness MVP (MVP ID M0005), which “focuses on the clinical theme of promoting quality care for patients in order to reduce the risk of diseases, disabilities, and death,” according

Proposed PFS: Get the inside scoop

Don't sleep on the vast number of policy and regulatory changes contained in the proposed 2024 Medicare physician fee schedule. In this policy-setting rule, discover what CMS has in store for your billing, coding, revenue cycle, and compliance operations with an in-depth review of the key proposals. Attend the live webinar **2024 Medicare Physician Fee Schedule: Get an Inside Look at CMS' Proposed Policy Updates** on Aug. 24. Learn more: <https://codingbooks.com/YMPDA082423>.

to the short descriptor for the measures set. CMS lists preventive medicine, internal medicine, family medicine and geriatrics as the most applicable specialties.

Other MVPs are narrower in scope. For example, CMS lists anesthesiology, which includes certified registered nurse anesthetists, as the most applicable specialty for the Patient Safety and Support of Positive Experiences with Anesthesia MVP (MVP ID G0059). According to the descriptor, CMS designed the MVP to improve the quality of anesthesia care and postoperative outcomes, promote patient safety and enhance patient satisfaction. “The measures are used for a variety of surgical procedures that anesthesiologists deliver care for, and are broadly applicable to anesthesiologists practicing within ambulatory, outpatient, and inpatient hospital settings,” CMS adds in the descriptor.

Even though the MVP program is optional, a wide range of practices attended the interactive webinar and had dozens of questions for CMS officials. Here is a wrap up of the most common questions.

You can run MIPS and the MVP

The most frequent questions during the webinar were whether a practice or group could participate in MIPS or an accountable care organization (ACO) and the MVP for the same reporting year, and how CMS will score practices that run both programs. The answers were “yes,” and CMS will assign the higher of the two scores. “Clinicians who are part of an ACO can submit traditional MIPS or an MVP, with the highest final score assigned to the clinician,” explained Chris Izui, MS, Center for Transforming Health, MITRE Corporation, who also participated in the webinar.

“We’ll score the MVP submission and the traditional MIPS submission and assign the higher of the two final scores,” Moira Marzen, health informatics solution coordinator lead for Telligen, a CMS contractor that offers QPP support, responded to a question about traditional MIPS and MVP.

The same scoring policy would apply to facility-based clinicians who participate in MIPS, Marzen explained in response to a question about facility scoring. “If a facility-based clinician reports an MVP and is eligible for facility scoring, we’ll calculate two scores, one for traditional MIPS (using facility scores) and one for their MVP reporting. The clinician will get the higher of these two scores,” Marzen said.

Webinar attendees also had questions about group participation. For example, if all eligible clinicians in a group participate as a group, they’ll receive the group’s score, Marzen explained. But if MVP isn’t appropriate for everyone in the group, clinicians who don’t participate in the MVP will need to stick with MIPS to avoid a MIPS penalty. “If you’re reporting an MVP at the individual level, the MIPS-eligible clinicians who don’t report the MVP would need to report traditional MIPS. If reporting an MVP as a subgroup, the MIPS eligible clinicians who aren’t in the subgroup would need to report traditional MIPS,” Marzen added.

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Stick to MIPS if MVP doesn't fit

Eligible clinicians should stick with traditional MIPS reporting if they don't find an MVP that fits, CMS officials advised. For example, “anyone can report on the Optimal Care for Kidney Health MVP as long as they register for and meet the requirements of the MVP. However, we encourage clinicians to report MVPs that are meaningful to their scope of care,” said Deb Kaldenberg, with CMS' Practice Improvement and Measures Management Support (PIMMS) contractor, in response to a question about reporting the MVP.

A webinar attendee from a radiology practice asked if it should participate in the MVP program even though CMS doesn't have an MVP for the specialty. “You would have to find [an MVP] that is clinically relevant for your practice. You are welcome to continue to report traditional MIPS,” Sugumar replied.

Missed measures will receive a 0

The Quality measure scoring system is another reason to make sure the MVP is right for potential participants. Participants must successfully report at least four quality measures from the set for their chosen MVP. CMS will assign a score of one to 10 for reported measures and zero for any missed measures.

A webinar attendee asked whether an MVP participant who reported fewer than the required four quality measures would receive a score on the measures the participant did report or an overall score of zero: “If you report less than the required number of quality measures, will you receive a score on what you do report or do you just receive an overall score of 0?”

CMS will score any submitted measures and assign a score of zero if a practice does not submit a measure, Izui replied.

CMS won't give providers who can't perform four measures a break on quality performance. A webinar attendee asked how CMS would know that a physical therapy practice had reported all measures available to them under the proposed musculoskeletal MVP, if it only had the ability to report three measures.

In effect, CMS will only look at what the provider did, answered Colleen Jeffrey, who is also with PMMI. “If a clinician/group registers for an MVP, it is a requirement to report on four quality measures. There would not be a denominator reduction for measures that were not reported. That is, if only three of the four

required quality measures were submitted, the performance denominator would remain 40,” Jeffrey said.

— *Julia Kyles, CPC* (jkyles@decisionhealth.com) ■

RESOURCE

- CMS MIPS Value Pathways: <https://qpp.cms.gov/mips/mips-value-pathways>

Medicare Advantage

On MA prior auth, Congress proposes relief — but CMS is ahead of the game

A couple of new bills — or rather, retreads of old bills — demonstrate increased congressional interest in reforming prior authorization (PA) under Medicare Advantage (MA). While the success of these bills is not assured, a recent proposed rule shows CMS is willing to move on this issue itself, with Congress serving more as a cheerleader than as a legal authority.

For years, plans that require PA for allowable services have bedeviled providers, who generally consider PA a way for cost-conscious private insurers to keep patients from getting needed services.

Traditional Medicare only rarely requires prior authorization for hospital outpatient department services, such as blepharoplasty and vein ablation. Medicare Advantage is a hybrid — part private, part government — but the private-sector managers of such plans have increasingly required PA for a host of services. As recently as 2008, CMS and the Government Accounting Office (GAO) expressed doubt that MA plans could require PA at all (*PBN 12/22/08*); in 2022, the Kaiser Family Foundation calculated that 99% of MA plans had some PA requirements.

The feds have been slow to push back, despite strong anti-MA sentiment in some quarters of Congress (*PBN 2/28/22*). But this is starting to change.

In December 2022, CMS released an interoperability proposed rule with a heavy PA reform component for MA; the rule is called “Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations.” If finalized as is, the rule would require MA organizations to develop application programming interfaces (API) and to use these to deliver PA results within seven days — though, in special circumstances, that minimum would be sped up to 72 hours (*PBN 12/19/22*).

And now some members of Congress are trying to support that rule with legislation. The Health Care Price Transparency Act of 2023 (H.R. 4822) that currently moved out of the House Ways and Means Committee is mostly about billing reforms in the manner of the No Surprises Act rules — for example, it requires hospitals to “publish gross and cash prices for all items and services and requires publication of prices for at least 300 shoppable services or a consumer-friendly price estimator tool” ([PBN 12/5/22](#)). But its architects have grafted language onto it from the as-yet-unpassed Improving Seniors’ Timely Access to Care Act (ISTACA) legislation that directly addresses PA under MA.

Sponsors have been pushing ISTACA since 2019, and its progress and prospects have improved incrementally ([PBN 5/24/21](#)). In 2022, the bill passed in the House but faltered in the Senate. Part of its downfall may have been the \$16 billion price tag the Congressional Budget Office (CBO) stuck on it and which supporters maintain is inflated; CMS has estimated that PA reform would actually save the government money ([PBN 12/19/22](#)).

Alina M. Czekai, vice president of strategic partnerships at Cohere Health, a prior authorization consultancy in Boston, as well as a former senior advisor to CMS Administrator Seema Verma, says “they’ve rolled [ITASCA] into a bigger health care package, which is the sort of thing Congress will sometimes do to try to move something forward — [in this case] hitching it to other bipartisan issues like price transparency.”

The Price Transparency bill’s Title III section (“Establishing Requirements with Respect to the Use of Prior Authorization Under Medicare Advantage Plans”) requires an “electronic prior authorization program” and “real-time decisions.”

Though similar in outline to the interoperability rule’s requirements, it is also vaguer about how these would be achieved, notes Robert Tennant, vice president, federal affairs for the Workgroup for Electronic Data Interchange (WEDI) in Washington, D.C.

For example, Tennant says, in its rule CMS “has proposed the Fast Healthcare Interoperability Resources (FHIR) standard that could result in real-time responses to some prior authorization questions.” The current bill largely avoids technical details.

Despite the bill’s vagueness, Tennant believes the introduction and reintroduction of the basic PA reform concepts in legislation is a good sign, and that the efforts to put these PA standards into law have emboldened CMS to go forward with its rule.

“I think this bipartisan, bicameral legislation signaled to CMS that there was interest on the Hill in solving prior authorization and that’s what led to the proposed rule and hopefully the final rule,” Tennant says.

Gold carded

Also before Congress: The Gold Card Act of 2023. A version of this bill was previously introduced by current sponsor Congressman Michael C. Burgess, M.D., (R-Texas) and his co-sponsor Vicente Gonzalez (D-Texas). Though the bill’s language has not been entered into the Congressional Record, Burgess’ office has announced that, like the previous version, it would require MA plans to “gold card” providers on procedures for which they have had at least 90% of their PA requests approved in the preceding year. These would include denials reversed on appeal.

Conceptually this is like a reverse image of the outlier feature of the Appropriate Use Criteria for advanced imaging that CMS tried to implement in a series of physician fee schedule rules and recently withdrew (*see story, p. 8*). That feature would have absolved most providers from PA on certain imaging procedures while requiring providers with poor approval records to undergo PA ([PBN 9/16/19](#)). The Gold Card Act instead rewards successful performers by relieving them of PA responsibilities.

The Gold Card bill is similar to one that became law in Texas last year — and to laws passed in Louisiana and West Virginia, and to bills pending in several other statehouses now. “It feels like every day a new state is proposing new legislation around prior authorization,” Czekai says.

One might consider this at least the beginnings of a groundswell. “We’re seeing things happening at a state level and at the commercial level — not as much as we would like, obviously, but they’re happening,” says Claire Ernst, director of government affairs at the Medical Group Management Association (MGMA).

(continued on p. 6)

Benchmark of the week

E/M fee preview: Care management service tops list with 26% pay jump

A number of services in the E/M category are on track for big pay gains in CY 2024, led by behavioral health care management (99484), set for a 26% jump to \$54 per service, and joined by two prolonged services codes (99415, 99416).

But the good news isn't everywhere. While the pay increases are significant for some services, a total of nine codes in the E/M family are part of the gains, according to a *Part B News* payment analysis factoring in the conversion factor cut and changes to relative value units (RVU) from the proposed 2024 Medicare physician fee schedule. That contrasts with dozens of E/M codes that will see reduced fees in CY 2024.

The charts below reveal the largest payment winners and losers among the E/M code set. Behind 99484 comes the 2020-effective blood pressure monitoring code 99473, featuring a 9% gain, albeit with a modest payment of \$14.08. The prolonged services codes receive an 8% boost for 99416 and 7% increase for 99415, and they also receive minor fees. On the opposing end, remote monitoring code 99454 suffers the largest percentage loss, at -7%, with fees shifting to \$47 in 2024 from \$50 in 2023. Also atop the list of fee fizzleers are interprofessional consult codes 99451 (-4%), 99446 (-3%) and 99448 (-3%), as well as home visit codes 99344 (-4%) and 99350 (-3%). – Richard Scott (rscott@decisionhealth.com); data reporting by Laura Evans, CPC (levans@decisionhealth.com)

Top E/M payment gainers, per code, CY 2024

Code	Description	Proposed 2024 non-facility pro fee	2023 non-facility pro fee	Percent change in non-facility setting
99484	Care mgmt svc bhvl hlth cond	\$54.03	\$43.04	25.55%
99473	Self-meas bp pt educaj/train	\$14.08	\$12.88	9.35%
99416	Prolng clin staff svc ea add	\$9.50	\$8.81	7.79%
99474	Self-meas bp 2 readg bid 30d	\$16.37	\$15.25	7.37%
99415	Prolng clin staff svc 1st hr	\$20.30	\$18.98	6.99%
99453	Rem mntr physiol param setup	\$19.65	\$19.32	1.72%
99425	Prin care mgmt phys ea addl	\$58.95	\$58.29	1.13%
99489	Cplx chrnc care ea addl 30	\$71.06	\$70.49	0.82%
99494	1st/sbsq psyc collab care	\$58.29	\$57.95	0.59%

Top E/M payment losers, per code, CY 2024

Code	Description	Proposed 2024 non-facility pro fee	2023 non-facility pro fee	Percent change in non-facility setting
99454	Rem mntr physiol param dev	\$46.83	\$50.15	-6.63%
99451	Ntrprof ph1/ntrnet/ehr 5/>	\$34.06	\$35.58	-4.28%
99344	Home/res vst new mod mdm 60	\$138.52	\$144.02	-3.82%
99493	Sbsq psyc collab care mgmt	\$137.54	\$142.67	-3.59%
99446	Ntrprof ph1/ntrnet/ehr 5-10	\$17.36	\$17.96	-3.36%
99448	Ntrprof ph1/ntrnet/ehr 21-30	\$52.40	\$54.22	-3.36%
99406	Behav chng smoking 3-10 min	\$14.41	\$14.91	-3.36%
99407	Behav chng smoking > 10 min	\$26.85	\$27.79	-3.36%
99350	Home/res vst est high mdm 60	\$180.77	\$186.38	-3.01%
99497	Advncd care plan 30 min	\$80.56	\$83.02	-2.97%

Source: Part B News analysis of data contained within the proposed 2024 Medicare physician fee schedule addenda files: www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notice/cms-1784-p

(continued from p. 4)

But will they pass?

There are signs that some insurers, at least, are acknowledging that some kind of reform is coming and are moving to get ahead of it.

Ernst notes that United Healthcare (UHC) announced in March that it would institute its own national Gold Card program and was “eliminating nearly 20% of current prior authorizations, as part of a comprehensive effort to simplify the health care experience for consumers and providers.”

Ernst notes, though, that the insurer announced around the same time that it would put in a more restrictive procedure PA policy on some basic gastrointestinal procedures. UHC recently reversed that policy “after a lot of pressure from provider organizations,” Ernst says.

As to UHC’s 20% cut, Ernst says a lot depends on whether the codes UHC exempts from PA are financially significant or “codes that are either approved 100% of the time or literally never billed.”

As to whether these bills are going to become law this year, Ernst is not optimistic. However, John Yount, chief innovation officer at health care management company FinThrive in Alpharetta, Ga., and his colleague, Jonathan Wiik, vice president of health care insights, think the Price Transparency bill with the ISTACA language has a chance.

ISTACA “passed the House with unanimous support last year but couldn’t get across the finish line in the Senate,” Yount and Wiik tell *Part B News* via email. “We think it has legs if properly funded and attached to a bipartisan bill ... A lot will depend on negotiations between various House committees over the next couple of months — if a bipartisan transparency package does move forward, prior authorization reforms will be included.”

Yount and Wiik are less confident about the Gold Card Act, notwithstanding statements of support for it from many leading health care organizations, including MGMA. “At this point in the year, with appropriations complexities coming, health care proposals that haven’t been marked up yet [are unlikely] to advance,” they add.

As to the CMS rule, a date for a final hasn’t been set, and major stakeholders have made requests that may delay the final or even require the proposed rule be reissued: A July 26 letter from the AMA, AHIP, the American Hospital Association (AHA) and the BlueCross

BlueShield Association to CMS strongly objected to some technical details CMS has proposed, including “standards for PA attachments” from a prior rulemaking that seem to conflict with standards in this rule. So whatever happens with Congress, CMS and PA under Medicare Advantage, you can expect it to take some time to come together. —

Roy Edroso (redroso@decisionhealth.com) ■

RESOURCES

- Kaiser Family Foundation, “Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings,” Aug. 25, 2022: www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/
- Congress.gov, Health Care Price Transparency Act of 2023 (H.R. 4822): www.congress.gov/bill/118th-congress/house-bill/4822/text?s=1&r=1&q=%7B%22search%22%3A%5B%22HR+4822%22%5D%7D
- Office of Rep. Michael C. Burgess, M.D., “Burgess and Gonzalez Work to Streamline Quality Care for American Patients” (Gold Card Act of 2023), July 31, 2023: <https://burgess.house.gov/news/documentsingle.aspx?DocumentID=403783>
- Letter from AMA et alia to CMS Administrator Chiquita Brooks-LaSure, “Re: Follow-up on Notice of Proposed Rule Making Regarding Adoption of Standards for Prior Authorization Attachments (CMS-0053-P),” July 26, 2023: www.aha.org/lettercomment/2023-07-27-letter-notice-proposed-rule-making-regarding-adoption-standards-prior-authorization-attachments

Health care reform

CMMI dementia model aims to aid unpaid caregivers, patients

CMS is launching a demonstration model that is not only aimed at dementia patients, a growing segment of U.S. health care consumers, but also designed to help these patients’ unpaid at-home caregivers via care coordination and “respite services.”

The Guiding an Improved Dementia Experience (GUIDE) Model, announced by HHS on July 31, will launch on July 1, 2024, and run for eight years. CMS’ Center for Medicare and Medicaid Innovation (CMMI) is accepting letters of interest until September 15 and will release a Request for Applications (RFA) form later in 2023.

The letter of interest form asks applicants whether they have experience supplying services such as “caregiver education and support” and “referral and coordination of social services and supports,” and with what sort of organizations they plan to partner to provide these under GUIDE, with “PACE [Program of All-Inclusive Care for the Elderly] Providers” and “Behavioral Health Centers/Providers” among the suggested choices (*see resources, below*).

CMMI references the Biden administration's April 2023 executive order (EO) aiming to “expand access to affordable, high-quality care, and provide support for care workers and family caregivers” in child and long-term care situations.

In that EO, the president directed HHS to create “a new dementia care model that will include support for respite care (short-term help to give a primary family caregiver a break) and make it easier for family caregivers to access Medicare beneficiary information and provide more support to family caregivers during the hospital discharge planning process.”

The CDC reported in 2019 that “by 2060, the number of Alzheimer’s disease cases [in the U.S.] is predicted to rise to an estimated 14 million people, with minority populations being affected the most.”

Under GUIDE, “participants will assign people with dementia and their caregivers to a care navigator who will help them access services and supports, including clinical services and non-clinical services such as meals and transportation through community-based organizations,” according to CMMI.

Providers must be prepared to assemble an interdisciplinary care team, which must include a “clinician with dementia proficiency as recognized by experience caring for adults with cognitive impairment; experience caring for patients 65 years or older; or specialty designation in neurology, psychiatry, geriatrics, geriatric psychiatry, behavioral neurology, or geriatric neurology.”

GUIDE providers will be reimbursed via an “alternative payment,” terms for which have yet to be revealed — though it will include per beneficiary per month (PBPM) payments and, for some safety net providers, a lump sum infrastructure payment “to support program development activities.” Part B-enrolled providers/suppliers, excluding durable medical equipment (DME) and laboratory suppliers will be eligible to provide GUIDE service; eligible patients will have a dementia diagnosis and Part B enrollment, and may not be enrolled in Medicare Advantage or Medicare hospice or reside in a long-term nursing home.

Under GUIDE, caregivers will get education on dementia care as well as “respite services, which enable them to take temporary breaks from their caregiving responsibilities.”

Respite services are not outlined in the current GUIDE materials, but a 1988 study in CMS’ library concerning an earlier demonstration model says these may include “adult day care centers, and nursing home services ... if they are offered for the purpose of providing the primary caregiver relief from his or her caregiving tasks.”

CMS has previously asserted its legal authority to support caregivers as well as patients in several venues, including a 2007 paper that describes respite care as part of services rendered in Medicare and Medicaid demonstration models as well as through Medicaid waiver programs and PACE. — *Roy Edroso* (redroso@decisionhealth.com) ■

RESOURCES

- HHS, “Biden-Harris Administration Announces Medicare Dementia Care Model,” July 31, 2023: www.hhs.gov/about/news/2023/07/31/biden-harris-administration-announces-medicare-dementia-care-model.html
- CMMI, “Guiding an Improved Dementia Experience (GUIDE) Model,” last updated Aug. 4, 2023: <https://innovation.cms.gov/innovation-models/guide>
- CMMI, LOI form: <https://app1.innovation.cms.gov/GUIDELOI/s/>
- White House, “FACT SHEET: Biden-Harris Administration Announces Most Sweeping Set of Executive Actions to Improve Care in History,” April 18, 2023: www.whitehouse.gov/briefing-room/statements-releases/2023/04/18/fact-sheet-biden-harris-administration-announces-most-sweeping-set-of-executive-actions-to-improve-care-in-history/
- CDC, “Minorities and Women Are at Greater Risk for Alzheimer’s Disease,” last reviewed Aug. 20, 2019: www.cdc.gov/aging/publications/features/Alz-Greater-Risk.html
- Health Care Financing Review, “Respite Care: Lessons From A Controlled Design Study,” Dec. 1988: www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/Downloads/CMS1192069dl.pdf
- CMS, “CMS’ Legal Authority to Support Caregivers,” Sept. 2007: www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/CMSCaregivers91907.pdf

Physician fee schedule

More coverage of the proposed PFS: Vaccine pricing, policy updates and more

Don’t miss out on yet more policy changes contained in the proposed 2024 Medicare physician fee schedule, from vaccine payments to the never-used Appropriate Use criteria and more. Get all the latest here:

- **Part B COVID in-home vaccine payment extended — and expanded.** For the pandemic, CMS cleared a \$40 payment for COVID shots, then extended it to the other preventive vaccines covered by Part B: pneumo-

coccal, influenza and hepatitis B ([PBN 6/21/21](#)). The agency also authorized a \$35.50 add-on for in-home COVID shots as a covered preventive benefit, or \$36.85 with the Medicare Economic Index (MEI) adjustment. CMS had planned to end these flexibilities at the end of the year in which the public health emergency (PHE) ended — that is, Dec. 31, 2023 — but now they’re proposing to not only extend it for another year at least, but to extend the in-home additional payments to the other three vaccines. However, CMS proposes “to limit the additional payment to one payment per home visit, even if multiple vaccines are administered during the same home visit.”

- **Appropriate Use scrubbed.** After years of evading a definitive start to the program required by the Protecting Access to Medicare Act (PAMA) of 2014, CMS all but admits that, despite the statutory requirement to implement an Appropriate Use Criteria program meant to prevent expensive imaging services from being misused, it has given up.

“Having considered many rounds of input from interested parties ... we have come to believe that 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,” the rule states.

Since this reporting is “critical” to AUC, and since the workarounds CMS considered to overcome the “unwieldiness” of the necessary process have proven insufficient, the agency has decided to “pause efforts to implement the AUC program for reevaluation and rescind current regulations.”

AUC was intended to use evidence-based guidelines created by “provider-led entities” to create clinical decision support mechanisms (CDSM) that would determine what imaging services would be payable on certain conditions and procedures, thus removing Medicare contractors’ role in determining those payments. AUC was also meant to identify outlier providers whose ordering would be subject to greater prior authorization scrutiny, the implication being that responsible providers would suffer less hassle in their orders.

But since blowing its first 2017 deadline, CMS has failed to fully implement the program ([PBN 11/9/15](#)). Industry groups such as the Medical Group Management

Association (MGMA) have repeatedly criticized the program and called on CMS and Congress to correct it ([PBN 9/17/18](#)). CMS has tried intermediary measures like a “testing year,” but with the promise that one day the full monty would be implemented ([PBN 9/12/19](#)).

CMS congratulates itself on having otherwise fulfilled the AUC mission, in spirit: “We believe that many goals of the AUC program have been met by the QPP and other more comprehensive accountable care initiatives,” such as the Medicare Shared Savings Program, electronic clinical quality measures (eCQM), Certified Electronic Health Record Technology (CEHRT) and other means, the rule says. Thus the agency proposes “to pause efforts to implement the AUC program for reevaluation and to rescind the current AUC program regulations at § 414.94” and is “not proposing a time frame within which implementation efforts may recommence.”

- **CEHRT definitions updated.** CMS says it is following the Office of the National Coordinator’s (ONC) proposal “to move away from ‘editions’” in certified electronic health record technology (CEHRT), such as “2015 CEHRT,” and proposing “incremental changes to individual measures under, but not limited to, the Medicare Promoting Interoperability Program, the Shared Savings Program, and the Quality Payment Program, which includes the MIPS Promoting Interoperability [PI] performance category and the Advanced APMs in recent years.”

So, instead of editions that roll up all separate recent changes to CEHRT requirements, such as information blocking rules, CEHRT definitions would “automatically incorporate ONC’s updates to relevant certification criteria without pursuing additional rulemaking” in what would be referred to as a “Base EHR definition.”

For 2024, CMS proposes that all participants in QPP and Shared Savings programs would have to report the MIPS Promoting Interoperability (PI) performance category measures “at the individual, group, virtual group, or APM entity level.” There would be a few extra requirements in the category, such as “attest[ing] to completion of the self-assessment of their implementation of safety practices,” according to ONC’s High Priority Safety Assurance Factors for EHR Resilience (SAFER) Guides, and the PI reporting period would be extended from 90 to 180 days. — *Roy Edroso* (redroso@decisionhealth.com) ■