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Regulatory UPDATE

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2024 Physician Fee Schedule

CMS has **issued a rule finalizing changes** to Medicare payments for physicians and other outpatient services, effective 2024. Key points:

- Cut in payments – Reduction of 3.4% to the base rate for payment under the fee schedule, known as the "conversion factor"
- Telehealth – A number of payment changes to Medicare payment for services administered by telehealth
- Drugs – Implementation of the Inflation Reduction Act, and changes to other existing policies for drugs covered under Part B

Who It Impacts

Primarily health care providers – but also their customers, including drug manufacturers.

Background on Physician Fee Schedule

A short aside: we always recommend a quick read of **MedPAC's payment basics** when diving into fee-for-service rules.

Medicare pays for a litany of services offered by physicians and other health professionals through the Physician Fee Schedule (PFS), including office visits, diagnostic services, therapeutic services….and on and on. These services are not necessarily just offered in the office setting – the PFS captures services in hospitals, post-acute settings, and other locations.

Broadly speaking, CMS sets the payment rate based on 1) the clinician work required to perform the service (Relative Value Units, or RVUs); 2) expenses related to maintaining a practice; and 3) professional liability insurance. Inputs can be modified to reflect prices in different markets, adjusted based on provider characteristics or geographic designations….and on and on. Under the PFS, Medicare typically pays for just the individual service – as opposed to other fee schedules, which incorporate bundles, pre-payment for services over a number of days, and other variables.

CMS updates the PFS through annual rulemaking, just as it does for other payment systems. The PFS moves with other Calendar Year rules, typically meaning a proposed rule in June or July, and a final by the end of October.

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Physician Payment

CMS has finalized a 3.4% reduction in the conversion factor for 2024. As noted earlier, the conversion factor is the base payment rate used to calculate payments under the Physician Fee Schedule.
There's a back story here. Several years ago, CMS finalized a policy that increased the relative weight for a number of different primary care-focused services. However, in the spirit of budget neutrality, increasing payments for those services caused a net reduction to the conversion factor, impacting physician payments across the board.

Why haven't we seen similar reductions play out in the past? For the past three years, Congress has stepped in with "patches" that prevent the full cuts from going into effect. True to form, in December 2022, Congress passed a two-year patch – albeit a smaller one than in previous years – providing a 1.25% increase to the conversion factor that CMS calculates for 2024.

However, even with the 1.25% bump, CMS came out at 3.4% - meaning that absent Congressional action, the reduction would have been even starker (4.55%).

We expect that Congress will again be asked to intervene, and provide additional relief to physicians in 2024.

Other highlights:

- Impact to specialties - As part of the annual update, CMS re-evaluates the relative payment rates for different specialties based on studies and other information. Table 119 in the rule provides a breakdown of which specialties are looking at increases and decreases relative to the previous year. Interventional radiology, radiology, nuclear medicine, and vascular surgery are some of the bigger losers, with a drop of 3% or more. Family medicine swings the other way, with a 3% bump.
- Evaluation and Management Add-On – The root of CMS' downward pressure on the conversion factor are a series of changes CMS made to increase payment for primary care related services several years ago. A key part of that proposal was a new add-on payment for certain evaluation and management visits for primary care that CMS made available. Congress prohibited CMS from implementing that add-on payment as part of its legislation to mitigate the impact of the cuts to the conversion factor – but only through 2023. CMS is re-establishing the code for billing effective January 2024, with some refinements. CMS has also adjusted its estimates on the impact of that add-on payment – which blunts by a third the redistributive impact of re-imposing the add-on code.
- Caregiver training – CMS finalized a policy to make payments for practitioners (physicians, nurse practitioners, and others) who train and involve caregivers in support of patients with certain diseases (e.g. dementia).
- Social Determinants of Health (SDOH) – Beginning in 2024, Medicare will begin paying separately for "Community Health Integration" (CHI), Social Determinants of Health Risk Assessment, and "Principal Illness Navigation" (PIN). These payments are intended to account for resources clinicians expend to involve community health workers, care navigators, and other non-clinical support staff in patient care. CHI refers to time spent to better understand a patient's environment/story, while PIN focuses on connecting beneficiaries with high-risk conditions for services.
- "Direct Supervision" – In some instances, CMS permits providers to bill for services provided by auxiliary staff (rather than the clinician) when the services are performed under the "direct supervision" of a clinician. During the Public Health Emergency (PHE), CMS permitted direct supervision to be provided by real-time video conferencing. CMS is extending that flexibility through 2024, indicating it has not received any sign of patient harm.

Telehealth

CMS continues the slow unwind of the COVID-19 PHE, during which CMS used emergency authorities to suspend many statutory constraints on Medicare payment for services offered under telehealth. CMS has direct control over which services are payable under telehealth.
Congress has provided some additional authority for CMS to waive constraints around the location of the patient, or the "originating site," as well as which clinicians are permitted to bill under telehealth, through 2024.

Key changes in the final rule:

- New services payable by telehealth – CMS adds health and well-being coaching services (2024 only) and SDOH health risk assessments to the list of services payable by telehealth.
- About that list…. – CMS proposes changes to how it assesses requests from stakeholders to add services to the list of services payable by telehealth.
- Unexpected increase for mental health services to the home – CMS pays for services at a (lower) facility rate and a (higher) non-facility rate, depending on the location of the clinician offering the services. During the PHE, CMS has been paying for most telehealth services at the non-facility rate, recognizing that many clinicians were unable to see patients in the office, and the resulting drop in revenue would be impactful. In last year's rule, CMS indicated it intended to return to paying for all services at the facility rate in 2024. However, in a curveball, CMS will continue paying for mental health services provided via telehealth to beneficiaries in the home at the non-facility rate.
- Implementing Congressional directive – As noted earlier, CMS proposes to implement the Congressional directive to extend some PHE-era policies through 2024 – including the originating site restrictions, changes to which providers can bill for telehealth, and authority to bill for audio-only services.
- Video conferencing for telehealth – Continuing the theme of direct supervision mentioned earlier – residents who provide care via telehealth are supposed to do so under the direct supervision of a teaching physician. CMS proposes to allow the supervising physician to offer that supervision through a real time video conference, rather than physically being in person, through 2024.
- Diabetes self-management – CMS will permit diabetes self-management training services to be offered via telehealth.

Drugs

CMS makes a few changes relative to payment for the administration of Part B drugs:

- IRA implementation – CMS finalizes a number of policy changes that Congress directed by the Inflation Reduction Act last August. Included – calculation of beneficiary coinsurance for Part B drugs whose costs increase faster than the rate of inflation and translating the $35/month out-of-pocket costs for insulin to Medicare Part B and home infusion settings.
- Wastage rebates – The bipartisan infrastructure bill included a new requirement for drug manufacturers to provide a rebate to CMS based on any wastage of Part B drugs sold in single-dose vials remaining after administration. CMS implemented that rule last year. This year, CMS makes some tweaks – including a new process for establishing "unique circumstances" exemptions that permit CMS to lower the rebate obligations on manufacturers, and new exceptions for low-volume doses and orphan drugs administered to a low number of unique beneficiaries.

Mental Health

A few highlights:

- Increase in payment – CMS will increase the relative value of timed behavioral health services under the PFS, specifically for psychotherapy.
- Medicare payment for new providers – At Congress' direction, CMS will begin allowing marriage and family therapists (MFTs) and mental health counselors (MHCs) to bill for mental health services under Part B. CMS will also allow addiction counselors to bill as mental health counselors. Those providers will need to enroll in Medicare.
- Psychotherapy for crisis services – Again at Congress' direction, CMS establishes new billing codes for psychotherapy for crisis services offered in non-facility settings (like the home or a mobile unit).
- Billing for Health Behavior Assessments and Intervention (HBAI) services – CMS will allow new providers – clinical social workers, MFTs, MHCs, and clinical psychologists – the opportunity to bill HBAI services.
- Flexibility for FQHCs and RHCs – CMS proposes to lower the level of supervision required for MHCs operating in Federally Qualified Health Centers and Rural Health Clinics, from direct supervision to general supervision.

ACOs and the QPP

CMS operates a number of Alternative Payment Models, in which providers enter agreements with the Medicare program to be paid differently for services, typically with a link to performance on quality measures. Among the most significant – the Medicare Shared Savings Program (MSSP), which supports Medicare's relationship with Accountable Care Organizations (ACOs).

CMS is making several changes to the MSSP (**detailed in a separate CMS fact sheet**), including:

- Calculation of financial targets ("benchmarks") – CMS has been modifying the methodology used to set the financial targets for ACOs, known as benchmarks, seemingly since the program launched. CMS again makes changes, including several focused on "risk adjustment" methodologies that adjust financial targets to account for the relative health of beneficiaries in the program.
- Attribution – Critical to assessing an ACO's performance is determining which beneficiaries an ACO should be accountable for. CMS uses an "attribution" methodology that uses fee-for-service claims histories to identify which beneficiaries should be included. CMS establishes a longer look-back period, which CMS argues more accurately tracks care patterns particularly for beneficiaries of underserved populations.

In 2015, Congress established a new paradigm in the Physician Fee Schedule with passage of the Medicare Access and CHIP Reauthorization Act (MACRA). MACRA established the Quality Payment Program (QPP), which gives providers the option of participating in an Advanced Alternative Payment Model – an APM with significant financial risk – or being subject to the Merit-Based Incentive Payment System (MIPS), under which providers are assessed nationally on their performance on certain measures, and receive positive or negative payment adjustments based on their relative performance.

CMS is making a number of changes to the QPP (detailed in (yet another) separate fact sheet), including:

- New MVPs – Several years ago, CMS began establishing MIPS Value Pathways (MVPs), intended to provide specialists with the opportunity to be assessed on performance measures more relevant to their practices. CMS is proposing five new MVPs, including women's health; ear, nose, and throat disorders; prevention of infectious diseases (inc. hepatitis and HIV); and mental health.
- Performance threshold – CMS had proposed to increase the performance threshold for MIPS and MVPs from 75 points to 82 points, creating a higher mark for providers to avoid a payment penalty. CMS did NOT finalize that proposal.

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Providers swimming in these waters should spend much more time with the fact sheet.

Other

And then the other (important!) stuff:

- Dental/oral health services – The Biden Administration and Congressional Democrats made a well-documented push to make Medicare cover a more robust set of dental services through the Build Back Better Act last Congress – a push that ultimately proved fruitless. In the interim, CMS has taken steps to broaden Medicare coverage of dental services within the parameters of its authority. Last year, CMS added a number of new services to those billable under the Physician Fee Schedule. CMS again expands coverage to new dental services, this time those linked to antiresorptive therapy, chemotherapy, and CAR T-cell therapy.
- Clinical Lab Fee Schedule – Medicare pays for laboratory services through the Clinical Laboratory Fee Schedule (CLFS). Congress directed a significant overhaul of how Medicare pays for laboratory-based tests in 2014 through the Protecting Access to Medicare Act (PAMA). To over-summarize, CMS was required to collect data on lab fees in the private sector and work that information into the Medicare payment methodology. However, disputes with how CMS approached the collection led to delays. Congress delayed implementation of the new methodology, most recently directing CMS not to reduce any rates in 2023, and to limit any reductions to 15% from 2024 to 2026. CMS implements the directive and adjusts the data collection and reporting periods for labs.
- Appropriate Use Criteria - A number of years ago, Congress directed CMS to establish an "Appropriate Use Criteria" program for diagnostic imaging, under which providers would be required to reference an automated decision-making tool prior to order certain types of imaging scans. CMS has delayed the final stage of implementation, which would create payment penalties, numerous times. CMS has now paused implementation efforts altogether in an effort to identify a "workable" implementation approach.
- Provider enrollment – Providers must first enroll in Medicare or Medicaid in order to bill those services. CMS makes some modifications to the existing rules of the road – including clarifying the length of time for which a Medicaid provider remains in CMS' database of terminated providers.

What it Means For You

This rule has a lot of things for a lot of folks.

However, what jumps off the page is CMS' decision to finalize a 3.4% reduction in the conversion factor. That's bad news for physicians and all providers paid through that schedule.

We highly anticipate the physician community will again ask Congress to intervene before the cuts take effect. Precedent suggests that Congress takes that request seriously.

What's Next

The rule takes effect January 1.

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Resources

CMS Press Release
CMS Fact Sheet – Physician Fee Schedule
CMS Fact Sheet – Medicare Shared Savings Program
CMS Fact Sheet – Quality Payment Program

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