CAPITOL STREET

July 13, 2023

Physician Pay -3%, Primary Care Boost ‘24

Cap to Risk Score Growth in MSSP (Negative), Equity & Oncology Care Focus

CMS released its proposed 2024 physician fee schedule (PFS) and attached policies that impact providers, technologies, and Part B drug manufacturers. Full rule can be found here.

Our Take & Next Up

Physicians get axed overall, with endocrinology & family practitioners as winners and surgeons, radiologists and nuclear medicine as losers. While this is a proposal; we see these as potentially being largely finalized as proposed. CMS is accepting comments on various topics including how to incorporate skin substitutes as a supply and coding, payment policies for complex non-chemotherapeutic drugs that are usually self-administered, as well as how to incorporate a new MSSP track that would offer a higher level of risk and potential reward. Stakeholders have until September 11, 2023, to submit comments. The final rule will be out on or around Nov 1, with new policies and payment rates starting Jan 1, 2024.

Key Points

PHYSICIAN PAY DETAILS

The proposed 2024 conversion factor is $32.75, a decrease of $1.14 compared to the 2023 conversion factor of $33.89. This takes into account the -2.17% budget neutrality adjustment, the 0% update adjustment factor, and the 1.25% payment increase for services.

Pay hikes go to primary care (+2-3%) and mental health (+2%), while the cuts go to radiology (-3%), nuclear medicine (-3%), and vascular/thoracic surgery (-4 to -5%) in ‘24. Impacts across specialties include endocrinology (+3%), family practice (+4%), independent (-3%), interventional radiology (-4%), and vascular surgery (-4%) and thoracic surgery (-5%) . Increases to primary and mental healthcare reflect the separate payment for the office/outpatient evaluation/management visit complexity add-on code, the Year 3 update to clinical labor pricing, and the proposed adjustment to certain behavioral health services.

CMS is clarifying the separate payment for the Office/Outpatient E/M visit inherent complexity add-on code (G2211), which is helpful. The O/O E/M visit add-on cannot be billed with visits reported on the same day as a minor procedure or another E/M visit. CMS expects the complexity add-on code would likely be reported with ~38% of all O/O E/M visits for 2024. If finalized, establishing payment for this code will have a lesser impact than initially estimated.

CMS is proposing to add a new Social Determinants of Health (SDOH) risk assessment as an optional element in the annual wellness visit (with an additional payment). This would be a separately payable assessment with $0 beneficiary cost sharing when furnished as part of the same visit as an annual wellness visit. The visit is a covered service for those who have not received an initial preventive physical examination, or wellness visit within the past 12 months. SDOH Risk Assessments would also be permanently added to the Medicare Telehealth Services List.

CMS is proposing to pay for certain caregiver training services and community health integration (cancer). When the treating practitioner identifies a need to involve and train one or more caregivers to assist the patient in a patient-centered treatment plan, CMS will pay. CMS is proposing separate coding and payment for community health integration (CHI) services and payment for Principal Illness Navigation services to help patients navigate cancer treatment and treatment for other serious illnesses. The CHI initiating visit would be an E/M visit and would serve as a prerequisite to billing for CHI services.

CMS is proposing MSSP policies that would increase participation by 10-20%. Several reforms to the Alternative Payment Model (APM) Performance Pathway (APP) and ACO assignment and risk calculations to increase MSSP participation

- A cap to risk score growth in an ACO's regional services area is also being proposed to encourage ACOs to care for medically complex, high -cost patients by reducing the impact of negative regional adjustment on the benchmark. The approach would modify the calculation of the regional component of the 3-way blended benchmark update factor (weighted 1/3 accountable care prospective trend (ACPT), and 2/3 national-regional blend) and cap prospective risk score growth in an ACO's regional service area between benchmark year three and the performance year in the same way that ACO risk score growth was capped in 2023 while accounting for an ACO's aggregate market share.
- CMS is also proposing to modify the assignment methodology and assignable beneficiary to account for individuals served by nurse practitioners, physician assistants and clinical nurse specialists. Under the proposal, CMS's stepwise beneficiary assignment methodology would include a new step three which would use an expanded window for assignment (a 24-month period). Beneficiaries likely to be added to the assignable population due to this proposal are more likely to be disabled, enrolled in the Medicare Part D LIS, or reside in areas with higher Area Deprivation Index (ADI) scores.
- CMS is proposing to modify the health equity adjustment underserved multiplier by using the number of beneficiaries, rather than person years, for calculating the proportion of the ACO's assigned beneficiaries who are enrolled in LIS or who are dually eligible for Medicare and Medicaid. Inclusion of beneficiaries with partial LIS enrollment in the underserved multiplier increases the incentive for ACOs to help facilitate LIS enrollment for beneficiaries.

BIOPHARMA / DIAGNOSTICS / MED TECH

Discarded drug refund clarification. CMS is proposing additional implementation policies including timelines for the initial and subsequent discarded drug refund reports to manufacturers, method of calculation when there are

multiple manufacturers for a refundable drug, increased applicable percentages for drugs with unique circumstances, and a future application process by which manufacturers may apply for an increased applicable percentage for a drug. As a reminder in the 2023 PFS, CMS finalized a policy to require manufacturer refund for discard amount of single-dose or single-use drug using the JW modifier.

CMS is proposing to expand coverage of diabetes screening tests to include the Hemoglobin A1c test. CMS is also proposing to extend the Medicare Diabetes Prevention Plan (MDPP) Expanded Model's Public Health Emergency Flexibilities, which would allow all suppliers to continue to offer MDPP services virtually through December 31, 2027.

Appropriate Use Criteria (AUC) for advanced diagnostic imaging will be paused and reevaluated. The program was a statutory requirement that directed CMS to collect real-time claims-based reporting for information on AUC consultation and imaging patterns for advanced diagnostic imaging services to inform outlier identification and prior authorization.

DENTAL & TELEHEALTH

CMS is proposing to allow payment for dental services prior to and during certain treatments for cancer. If finalized, Part A & B payments will be made for oral or dental examination, and necessary treatment, performed prior to and during certain cancer treatments or drug therapies associated with managing cancer related care. CMS is also collecting comments on any other cardiovascular interventions where dental care may be linked to its clinical success.

PHE telehealth flexibilities are extended through CY 2024 as required by law. These flexibilities include removing the geographic and location restrictions, the temporary expansion of practitioner types that can bill for telehealth, delaying the in-person visit requirement for tele-mental health services, and extending audio-only flexibility for certain services. Telehealth service payment for RHCs and FQHCs is extended until December 31, 2024, as required by law. CMS is also proposing to add health and well-being coaching services to the Medicare Telehealth Services List temporarily for CY 2024 and allow for payment of diabetes self-management training, and outpatient therapy services when furnished by institutional staff to beneficiaries in their home.

MENTAL HEALTH

Providers that may bill for mental health services: counselors & family therapists. Starting on January 1, 2024, marriage, and family therapists (MFT) and mental health counselors (MHC) will be eligible mental health practitioners and eligible for billing and telehealth flexibilities. CMS is proposing new CPCS codes under the PFS for psychotherapy for crisis services that are furnished in a home or mobile unit as directed by law. This payment amount for these psychotherapy for crisis services shall be equal to 150% of the fee schedule amount for non-facility sites of service.

Opioid Treatment Programs (OTPs) will be allowed to use audio-only communication for periodic assessments when two-way communication is not available. This is available through the end of 2024.

Ipsita Smolinski

Managing Director | Capitol Street

ipsita@capitol-street.com

900 19th Street, NW 6th Fl
Washington DC 20006

202.250.3741

www.capitol-street.com
