CAPITOL STREET

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Physician Pay -3.4% (2024) as Food Fight Simmers

Specialists Seek Congressional Fix

Today, CMS released its final 2024 physician fee schedule and attached policies that impact providers, technologies, and Part B drug manufacturers (here).

⋙ Our Take & Next Up

Physicians get axed overall (-3.4%, slightly deeper than –3.3% proposed), with endocrinology & primary care as winners and surgeons, radiologists, & nuclear medicine as losers. The final rule largely reflects what was proposed in July with new policies and payment rates starting Jan 1, 2024. This is the second consecutive year reimbursement rates will decline for physicians and even primary care providers may see a hit, I.e., office-setting. As a reminder, in 2022, Congress passed legislation to blunt prior cuts, and a similar legislative fix may be considered before year-end. Earlier today, the Senate Finance committee (Chair Wyden, D-OR) released a draft bill to address physician payment cuts as part of a larger healthcare package (mental health, PBMs included) to be marked up on November 8. However, the Senate Finance bill only stems cuts of 1.25%, under half of the current cut percentage, and providers are still expected to take a financial hit in CY 2024.

⋙ Key Points

PHYSICIAN PAY DETAILS

Primary care (+1-3%) and mental health (+2%) pay are up, while the cuts go to radiology (-3%), nuclear medicine (-3%), physical & occupational therapy (-3%) and vascular/thoracic surgery (-2-3%). Impacts across specialties include endocrinology (+3%), family practice (+3%), anesthesiology (-2%), interventional radiology (-4%), and vascular surgery (-3%) and thoracic surgery (-2%). 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. The decrease for specialties, reflect decreases in pay relative to other specialties, resulting from the redistributive effects, revaluation of individual procedures, as well as decreases resulting from the continued phase-in implementation of the previously finalized supply and equipment pricing updates.

The 2024 conversion factor is $32.74 ($0.01 less than proposed), a decrease of $1.15 (-3.4%) compared to the 2023 conversion factor of $33.89. This takes into account the -2.18% budget neutrality adjustment, the 0% update adjustment factor, and the 1.25% payment increase for services.

MSSP, SOCIAL DETERMINANTS & OTHER POLICIES

CMS clarifies the separate payment for the Office/Outpatient E/M visit inherent complexity add-on code (G2211). CMS finalized that the add-on code cannot be billed with an office or outpatient evaluation and management visit that is itself focused on a procedure or other service. CMS expects the complexity add-on code would likely be reported with ~38% of all O/O E/M visits for 2024 (unchanged).

CMS finalizes addition of the new Social Determinants of Health (SDOH) risk assessment as an optional element in the annual wellness visit (with an additional payment). This is 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 will also be permanently added to the Medicare Telehealth Services List.

CMS is finalizing its proposal to pay when practitioners train caregivers to support patients with certain diseases or illnesses (e.g., dementia) in carrying out a treatment plan. Medicare will pay for these services when furnished by a physician or a non-physician practitioner or therapist as part of the patient's individualized treatment plan or therapy plan of care. Additionally, CMS will include 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 is an E/M visit and will serve as a prerequisite to billing for CHI services.

CMS finalizes MSSP policies to increase participation by 10-20%. Reforms to the Shared Savings Program aim to increase provider participation:

- For 2024 and beyond, CMS is establishing the Medicare Clinical Quality Measure (CQM) as a new collection type for Shared Savings Program ACOs. CMS will provide all ACOs with a list of beneficiaries eligible for Medicare CQMs each quarter. Standards for data completeness, benchmarking, and scoring ACOs for the Medicare CQM collection type will align with MIPS benchmarking and scoring policies.
- CMS will delay the Shared Savings Program CEHRT requirement with MIPS by one year.
- CMS will recognize beneficiaries with partial year for the Health Equity Adjustment Underserved Multiplier.
- A cap to risk score growth in an ACO's regional services area was also finalized to encourage ACOs to care for medically complex, high -cost patients by reducing the impact of negative regional adjustment on the benchmark. The approach modifies 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 caps 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.
- Assignment methodology and assignable beneficiary is modified to account for individuals served by nurse practitioners, physician assistants and clinical nurse specialists. CMS's stepwise beneficiary assignment methodology includes a new step three which uses an expanded window for assignment (a 24-month period). Beneficiaries added to the assignable population due to this are disabled, enrolled in the Medicare Part D LIS, or reside in areas with higher Area Deprivation Index (ADI) scores. Methodology change is expected to grow assignable beneficiaries by more than 760,000.
- "Advance investment payments" are finalized with new ACOs having the option to received advanced shared savings payments. ACOs will also be allowed to early renew its participation agreement after its second performance year without triggering full recoupment of advance investment payments at that time.

BIOPHARMA / DIAGNOSTICS / MED TECH

Discarded drug refund clarification. CMS finalizes 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.

IRA Part B policies are finalized. CMS fulfilled statutory requirements from the IRA including amending the payment limit for new biosimilars during the initial period, requiring beneficiary coinsurance to be based on the inflation-adjusted payment amount (if exceeding the inflation-adjusted amount), and implementing the $35 copay cap for insulin furnished through a durable medical equipment.

CMS will maintain and expand the additional payment for in-home COVID-19 vaccine administration. The additional payment is now extended to administration of the pneumococcal, influenza, and hepatitis B vaccines when provided in the home. Payment will be limited to one payment per home visit, even if multiple vaccines are administered during the same home visit. The additional payment amount will be annually updated using the percentage increase in the Medicare Economic Index and adjusted to reflect geographic cost variations.

CMS expands coverage of diabetes screening tests to include the Hemoglobin A1c test. CMS finalizes proposal 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 is rescinded. 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

Dental: CMS will pay for dental services prior to and during certain treatments for cancer. 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 also codified previously finalized payment for dental services for head and neck cancer treatments, whether primary or metastatic.

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 also finalized adding 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. Telehealth services furnished to people in their homes will be paid at the non-facility PFS rate.

MENTAL & BEHAVIORAL HEALTH

Counselors & family therapists may bill for mental health services. 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 also finalized their **propo**sal to allow addiction counselors or drug and alcohol counselors who meet the applicable requirements to enroll in Medicare as MHCs

CMS will include CPCS codes under the PFS for psychotherapy 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.

Health Behavior Assessment and Intervention (HBAI) services (CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168) can be billed by clinical social workers, family therapists, and MHCs, in addition to clinical psychologists. Health Behavior Assessment and Intervention codes are used to identify the psychological, behavioral, emotional, cognitive, and social factors included in the treatment of physical health problems.

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 I Capitol Street
ipsita@capitol-street.com

202.250.3741 I www.capitol-street.com

900 19th St NW 6th Fl
Washington, D.C. 20006

CAPITOL STREET
