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On November 2, the Centers for Medicare and Medicaid Services (CMS) released the Calendar Year (CY) 2024 Medicare Physician Fee Schedule (MPFS) Final Rule, which ***adopts the proposed conversion factor of $32.74 resulting in a 3.4% decrease from the 2023 rate.*** *Industry groups claim that continuing reductions in reimbursement in an era of rising costs is unsustainable and will have a negative impact on Medicare patients' access to care. This article recaps the key provisions contained in the rule and current activity in the push for legislative changes.*

Summary of Key Changes from Proposed Rule

Most of the key provisions in the Final Rule align closely to what was originally proposed. However, there were a few changes that are described in more detail in the applicable sections of this article, including.

- Additional clarification regarding when the new add-on code, G2211, can be used.
- New definition of "substantive portion" of the visit for split/shared billing, and adoption of this definition effective in 2024 rather than 2025.
- Modified definition of "caregiver" in connection with caregiver training services that are reimbursable beginning in 2024.
- Modifications to various provisions of various services addressing health-related social needs, including the removal of certain frequency limitations and expansion of the types of visits that can serve as an initiating visit for these services.
- Leaving the MIPS performance threshold at 75 points for the 2024 performance year, which impacts 2026 payments, rather than raising it to 82 points.

Conversion Factor

Consistent with the rate reflected in the proposed rule, CMS finalized a conversion factor of **$32.74** for 2024, which is a **decrease of $1.15 (3.4%) from the current rate**. This marks the fourth consecutive year of decreases.

Medicare reimbursement for professional services is generally determined by multiplying the applicable relative value unit (RVU) amounts for billed services by the conversion factor in place on the date the service was rendered (adjusted for the specific locality). Significant volatility in the conversion factor began in 2021 in response to significant increases in Work RVUs (wRVUs) for many office visits and similar services that were determined to be undervalued historically. The increase in wRVUs resulted in a significant reduction in the conversion factor to achieve budget neutrality, as required by law. Congress intervened and staved off the expected 10.2% reduction. However, the impact of the wRVU increases remained, so the conversion factor for 2022 was once again set to be significantly reduced in light of budget neutrality requirements. Again, the rate was increased as a result of last-minute legislation. Continuing the pattern, legislation passed at the end of 2022 averted what would have been a 4.5% decrease in the conversion factor. This legislation also stipulated that a 1.25% adjustment would be applied to the rates that would otherwise be calculated by CMS for 2024, which ultimately yields a 3.4% decrease in the conversion factor based on the CY 2024 MPFS Final Rule compared to the rate in effect for 2023. The anesthesia conversion factor has followed a similar storyline.

The following table summarizes the trends in the Conversion Factor and the Anesthesia Conversion Factor, after legislative adjustments, for the last several years:

Year	Original Conversion Factor	% Change	Legislative Fix	Adjusted Conversion Factor	% Change	Anesthesia Conversion Factor	% Change
2019	$ 36.0391			$ 36.0391		$ 22.2730	
2020	$ 36.0896	*0.1%*		$ 36.0896	*0.1%*	$ 22.2016	*(0.3%)*
2021	$ 33.6319	*(6.8%)*	3.75%	$ 34.8931	*(3.3%)*	$ 21.5600	*(2.9%)*
2022	$ 33.5983	*(0.1%)*	3.00%	$ 34.6062	*(0.8%)*	$ 21.5623	*0.0%*
2023	$ 33.0607	*(1.6%)*	2.50%	$ 33.8872	*(2.1%)*	$ 21.1249	*(2.0%)*
2024	$ 32.3334	*(2.2%)*	1.25%	$ 32.7375	*(3.4%)*	$ 20.4349	*(3.3%)*
Cumulative Change: 2019 - 2024	$ (3.71)	*(10.3%)*		$ (3.30)	*(9.2%)*	$ (1.84)	*(8.3%)*

Sequestration Impact

The rates reflected above do not reflect the 2% Medicare sequestration cut stemming from a 2011 law (the Budget Control Act) that required across-the-board spending cuts for the federal government from fiscal year (FY) 2013 to FY 2030. Sequestration refers to automatic spending cuts required due to historical and current federal budget deficits resulting in national debt. Subsequent legislation provided relief to providers during the COVID-19 pandemic by suspending Medicare sequestration from May 1, 2020 through March 31, 2022. A 1% reduction resumed from April 1 through June 30, 2022, with the full 2% cut resuming effective July 1, 2022, and remaining in effect through FY 2032. The sequestration adjustment only applies to the portion of the payment made by Medicare and excludes the patient share.

Additionally, the Statutory Pay-As-You Go Act (PAYGO) enacted in 2010 requires spending cuts across the federal government if legislation enacted in a year results in an increase in projected budget deficits. To date, the PAYGO sequestration has never been triggered, and the Consolidated Appropriations Act, 2023 postpones these spending cuts until at least 2026. However, PAYGO sequestration, including a 4% reduction to Medicare payments, could be triggered in early 2026 unless legislative action is taken before then. However, neither the Budget Control Act nor the Statutory PAYGO Act include explicit directions as to how the two sequesters would be implemented together.

Other Provisions

The 2024 MPFS Final Rule contains additional provisions that impact billing and reimbursement for a variety of services. Key components are recapped below.

Evaluation/Management Complexity Add-On Code

A separate add-on code – HCPCS code G2211 – will be separately reimbursable beginning January 1, 2024. This code is intended to provide additional reimbursement to compensate for the increased time and resources related to the intensity and complexity inherent in office or outpatient evaluation/management (E/M) visits that are part of ongoing care related to a patient's single, serious, or complex condition. CMS believes that the values attributed to the office/outpatient E/M code set do not adequately account for these additional resources, regardless of the visit level. The add-on code was added to the MPFS in 2021 as a bundled code, but not eligible for separate reimbursement due to the Consolidated Appropriations Act, 2021 (CAA 2021), which placed a moratorium on Medicare payment under the MPFS for such a code. However, this moratorium expires on December 31, 2023.

The add-on code may not be utilized when an E/M code is billed with payment modifier 25, which is used to indicate that a minor procedure was performed on the same day. This is because the separately identifiable visits have resources that are, in the view of CMS, sufficiently distinct from the codes associated with furnishing stand-alone E/M visits to warrant different payment.

CMS estimates that the add-on code G2211 will be billed with 38% of all office/outpatient E/M visits initially, rising to 54% when fully adopted. Usage is expected to be highest among primary care specialties, since they are most often the ones establishing longitudinal relationships with patients. Surgical specialties are likely to have the lowest utilization of the add-on code, with other specialists somewhere in between.

> Approximately 90% of the budget neutrality adjustment is attributable to the redistributive impact of the new add-on code G2211.

In the Final Rule, CMS notes that Medicare Payment Advisory Commission (MedPAC) did not support the proposal to establish payment for the add-on code because of ambiguity regarding the code's use and the resource costs it is intended to reflect, as well as concern that the code may be misused and could duplicate payments for other services. Regardless, CMS maintains that there are "longstanding issues with coding and valuation" of office/outpatient E/M services that do not fully "distinguish and account for resource costs for primary care and other longitudinal care for complex patients," and that "until changes to coding and valuation are made to specifically address the underrecognition of the complexity inherent to these kinds of visits…, the RVUs on the PFS would otherwise perpetuate the systemic undervaluation of primary and longitudinal, non-procedural care."

The Final Rule does provide additional clarification of when the G2211 code can be used. Specifically, it notes that it is the *relationship* between the patient and the practitioner that is the determining factor of when the add-on code should be billed rather than the characteristics of particular patients or the length of the visit, which can already be addressed through E/M visit levels, care management codes, and prolonged service codes. This relationship involves the practitioner being the continual focal point for all needed health services, or for ongoing care related to a patient's single serious or complex condition.

The addition of this new code contributes significantly to the estimated overall impact of the MPFS on various specialties. CMS noted that approximately 90% of the budget neutrality adjustment is attributable to the redistributive impact of this code, with all other proposed valuation changes making up the other 10%. Accordingly, primary care and other office-based physician specialties are more likely to experience a positive increase in RVUs as a result of the changes, while surgical and hospital-based specialists are more likely to see a decrease.

Split/Shared Evaluation/Management Visits

Split/Shared visits are those inpatient E/M visits where the service is jointly provided by a combination of a physician and a non-physician provider (NPP). Previous rulemaking sought to require that such visits must be billed under the provider number of the individual providing more than half of the total visit time. However, the implementation of the proposed change has been delayed multiple times. Instead, CMS has allowed providers a choice in determining which clinician provided the "substantive portion" of the visit. Although the CY 2024 proposed rule called for another extension of the current approach through the end of 2024, **the Final Rule makes the new approach effective in 2024 but modifies the definition of "substantive portion."** In response to public comments, the definition moves away from the strict time-based determination that had previously been contemplated. Instead, "substantive portion" is defined to mean more than half of the total time spent by the physician and NPP performing the split/shared visit, or a substantive part of the medical decision making as defined by Current Procedural Terminology (CPT). For critical care visits that do not use medical decision making, "substantive portion" continues to mean more than half of the total shared time. If the NPP performs the "substantive portion" of a visit, it must be billed under the NPP's provider number, which results in a 15% reduction to the reimbursement rate.

Behavioral Health Services

The Final Rule implements certain provisions of the Consolidated Appropriations Act, 2023 (CAA 2023) relating to certain behavioral health services. These provisions allow services provided by marriage and family therapists (MFTs) and mental health counselors (MHCs) to qualify for payment under the MPFS. Additionally, addiction counselors and alcohol and drug counselors that meet applicable requirements, including statutory and regulatory requirements regarding education (master's or doctor's degree), clinical supervised experience, and applicable state licensure, can also enroll in Medicare as MHCs and bill for services beginning January 1, 2024. Further, this provision is extended to qualified individuals who are licensed in their state to furnish mental health counseling under a different title. Payment amounts for services provided by clinical social workers (CSWs), MFTs, and MHCs will be 80% of the lesser of the actual charge for the services or 75% of the amount determined for clinical psychologist services under the MPFS. The Final Rule also allows certain CPT codes for Health Behavior and Intervention Services to be billed by CSWs, MFTs, and MHCs, in addition to clinical psychologists.

CMS is also establishing a new HCPCS code for crisis psychotherapy services furnished on or after January 1, 2024, at any place of service, other than an office setting, for which the non-facility rate would apply. This would include the patient's home, temporary lodging, or other nearby location. The payment rate for these services shall be 150% of the corresponding fee schedule amount for non-facility sites of service. Expected expenditures under this provision are excluded from the budget neutrality calculation, in accordance with the provisions of the law.

The Final Rule adopts a 19.1% increase to the work RVUs for psychotherapy codes payable under the MPFS, essentially incorporating the E/M complexity add-on code work RVUs. This adjustment is in response to the acknowledgement that the country is in a behavioral health crisis and access to care is being inhibited by a shortage of providers. Accordingly, immediate steps must be taken to improve the accuracy of the valuation for psychotherapy services to reflect the complexity of care and the time spent on these visits. Given the significance of this adjustment, CMS will implement this increase over a four-year period, consistent with the Proposed Rule.

Telehealth Services

The CAA 2023 included several provisions extending telehealth flexibilities that were established during the COVID pandemic. The Final Rule implements these provisions, which include the following:

- The requirement for an in-person visit within six months prior to an initial mental telehealth service, and at subsequent intervals thereafter, will be delayed until January 1, 2025.

- Telehealth originating sites will continue to include any site in the United States where a beneficiary is located at the time of the service, including the patient's home, through December 31, 2024.
- The definition of telehealth practitioners will continue to include qualified occupational therapists, physical therapists, speech-language pathologists, and audiologists through December 31, 2024. Marriage and family therapists and mental health counselors will also be included as distant site practitioners for purposes of furnishing telehealth services.
- Specific telehealth services permitted to be furnished using audio-only technology as of December 29, 2022, will continue to be permitted through December 31, 2024.
- Payment for covered telehealth services, including those furnished by rural health clinics (RHCs) and federally qualified health centers (FQHCs), will continue through December 31, 2024.

Telehealth services provided to patients in their homes will be paid at the non-facility MPFS rate, while services provided to patients in other settings will continue to be paid at the MPFS facility rate. The Final Rule also removes the telehealth frequency limitations for inpatient hospital visits, nursing facility visits, and critical care consultation services through 2024.

Physicians may continue utilizing real-time audio and video interactive telecommunication to meet direct supervision requirements through the end of 2024. Teaching physicians would also be allowed to have a virtual presence during the provision of telehealth services in 2024 but must provide real-time observation utilizing audio/video technology (not audio-only). Additionally, current flexibilities that allow audio-only telecommunications for periodic assessments in connection with opioid treatment programs would be extended throughout 2024, but only in cases where the beneficiary does not have access to two-way audio-video communications technology.

Health and well-being coaching services would be added as approved telehealth services on a temporary basis through 2024, while Social Determinants of Health Risk Assessments would be added to the list permanently. Additionally, CMS removed the current requirement that Diabetes Self-Management Training be furnished in-person, noting that providing this service via telehealth would promote access to this underutilized service.

Newly Eligible Services

The Final Rule adopts several provisions to provide payment for services that have previously not been eligible for Medicare reimbursement. These include:

- **Caregiving Training Services** – Payment will be provided to practitioners who train caregivers to support patients with certain diseases or illnesses in carrying out a treatment plan. The Final Rule expanded the definition of a caregiver from what was originally proposed.
- **Health-Related Social Needs** – Payment will be made separately for the following services to account for resources when clinicians involve community health workers, care navigators, and peer support specialists in furnishing medically necessary care:
    - **Social Determinants of Health (SDOH) Risk Assessment** – This refers to a review of an individual's identified social risk factors that influence the diagnosis and treatment of medical conditions through a standardized, evidence-based tool. This is not intended to be a screening, but rather an assessment tied to one or more SDOH needs that may interfere with the practitioner's diagnosis or treatment plan. This code may be billed with a qualifying initiating visit.
    - **Community Health Integration (CHI)** – These are services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner, that address unmet SDOH needs.
    - **Principal Illness Navigation (PIN)** – This refers to providing individualized help to a patient, and possibly their caregiver, to identify appropriate practitioners and providers for care needs and support, and help them access necessary care timely. This may be billed

with a qualifying initiating visit.

- **Dental and Oral Health Services –** Dental exams and necessary treatments prior to treatment for head and neck cancers or other specified medical services such as chemotherapy will qualify for Medicare payment beginning in 2024.

Medical Shared Savings Program

The Merit-Based Incentive Payment System (MIPS) was established to apply bonus payments or penalties to physicians – up to 9% – in connection with metrics associated with quality, cost, and use of electronic health records. In the Proposed Rule, CMS sought to increase the MIPS performance threshold from 75 points to 82 points for the 2024 performance year, which impacts 2026 payments. CMS had estimated that approximately 46% of MIPS-eligible physicians would receive a negative payment adjustment under the higher threshold, as compared to 22% if the threshold stayed at 75. The Final Rule instead establishes the threshold at 75 points for the 2024 performance period / 2026 payment period (consistent with the threshold in place for the most recent two performance periods) in response to concerns raised in public comments.

Specialty Impact

CMS performed an analysis to estimate the ranges of impact for practitioners within each specialty, based on 2022 utilization data. The expected impact reflected in the Final Rule is only negligibly different from what was published in the Proposed Rule. According to this analysis, many specialties will see a minimal change (plus or minus 1%) in Total RVUs as a result of the provisions reflected in the Final Rule, including the following:

- Allergy/Immunology;
- Cardiology;
- Dermatology;
- Gastroenterology;
- General Surgery;
- Geriatrics;
- Hand Surgery;
- Independent Laboratory;
- Infectious Disease;
- Internal Medicine;
- Interventional Pain Management;
- Nephrology;
- Neurology;
- Neurosurgery;
- Obstetrics/Gynecology;
- Ophthalmology;
- Orthopedic Surgery;
- Otolaryngology;
- Pediatrics;
- Physical Medicine;
- Plastic Surgery;
- Podiatry;
- Pulmonary Disease; and
- Urology.

For these specialties, the most significant impact comes in the form of the lower Conversion Factor, which when applied to a similar level of Total RVUs will yield lower revenue.

However, there are some “winners” and “losers” that are anticipated to see more significant swings in Total RVUs. Those expected to see an increase are generally office-based practitioners who are likely to be higher utilizers of the E/M Complexity Add-On code. These specialties may also benefit from the new codes for caregiver training and health-related social needs. Additionally, this list includes some practitioners in the behavioral health arena. For these specialties, the increase in Total RVUs may mitigate the impact of the decreased Conversion Factor.

Specialty	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Endocrinology	1%	1%	0%	3%
Family Practice	2%	2%	0%	3%
Clinical Psychologist	1%	0%	0%	2%
Clinical Social Worker	2%	0%	0%	2%
General Practice	1%	1%	0%	2%
Hematology/Oncology	1%	0%	0%	2%
Nurse Practitioner	1%	1%	0%	2%
Physician Assistant	1%	1%	0%	2%
Psychiatry	1%	1%	0%	2%
Rheumatology	1%	1%	0%	2%

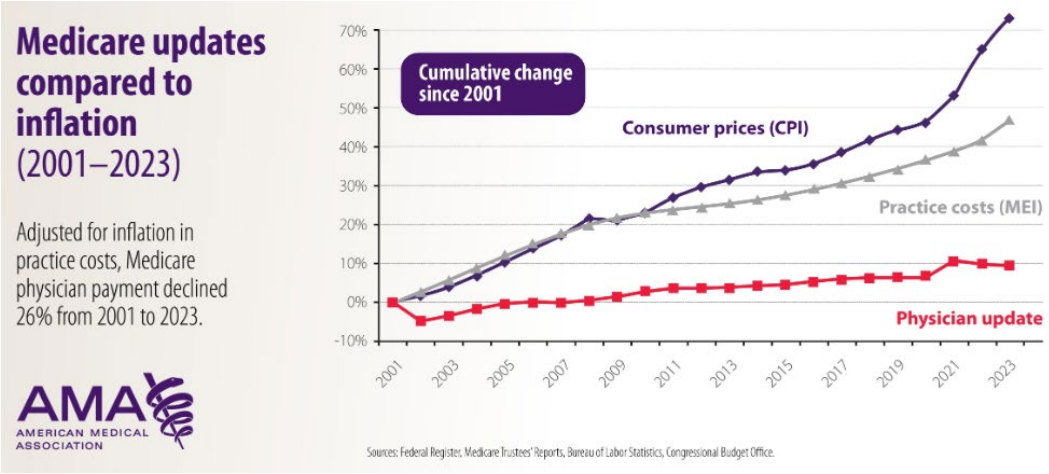
On the other hand, hospital-based providers and those less likely to have a longitudinal relationship with the patient are most likely to see a decrease in Total RVUs since they will not often qualify to bill for the newly established services. Changes to practice expense RVU values have a significant impact on the projected overall impact of the RVU changes for these specialties. Unfortunately, these practitioners will have the compounded impact of reduced RVUs and a reduced conversion factor, which will result in even lower reimbursement.

Specialty	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Interventional Radiology	-1%	-3%	0%	-4%
Nuclear Medicine	-1%	-2%	0%	-3%
Physical/Occupational Therapy	-1%	-2%	0%	-3%
Radiology	-1%	-2%	0%	-3%
Vascular Surgery	-1%	-3%	0%	-3%
Anesthesiology	-2%	-1%	0%	-2%
Audiologist	-1%	-1%	0%	-2%
Cardiac Surgery	-1%	-1%	0%	-2%
Chiropractic	-1%	-1%	0%	-2%
Colon And Rectal Surgery	-1%	-1%	0%	-2%
Critical Care	-1%	0%	0%	-2%
Diagnostic Testing Facility	0%	-1%	0%	-2%
Emergency Medicine	-2%	-1%	0%	-2%
Nurse Anes / Anes Asst	-2%	0%	0%	-2%
Optometry	-1%	-1%	0%	-2%
Oral/Maxillofacial Surgery	-1%	-1%	0%	-2%
Pathology	-1%	-1%	0%	-2%
Radiation Oncology And Radiation Therapy Centers	0%	-2%	0%	-2%
Thoracic Surgery	-1%	-1%	0%	-2%

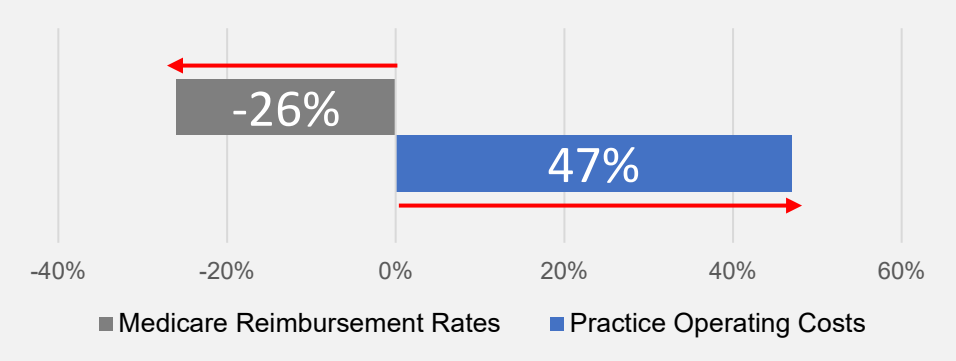
Industry and Legislative Response

Even before CMS released the CY 2024 MPFS Proposed Rule, industry advocates were pushing for change. The American Medical Association president notes that several factors have led to a physician shortage, including administrative challenges, consolidation in the industry that shifts power away from patients and physicians to large health systems and insurers, and declining Medicare reimbursement rates.

AMA has emphasized that on an inflation-adjusted basis, Medicare physician payment has been cut 26% since 2001:



The AMA maintains that at the same time, the cost of operating a practice has increased by 47%, according to the Medicare Economic Index (MEI), a measure of practice cost inflation that was established decades ago to estimate changes in operating costs. This dynamic has created a widening gap between expenses and reimbursement that threatens the long-term viability of the Medicare physician payment model and Medicare beneficiaries' continuing access to care.



In response, the AMA is encouraging Congress to "establish a permanent, annual inflationary Medicare physician payment update that keeps up with the cost of practicing medicine and encourages practice innovation," and abandon budget neutrality requirements.

The push for a change is coming from other avenues as well. In its March 2023 report to Congress, the Medicare Payment Advisory Commission (MedPAC) noted that the MEI has been growing at a pace in excess of historical norms for the last several years, and these cost increases may be difficult for practitioners to absorb. The MEI was originally developed to establish Medicare physician payment updates that correspond to the estimated changes in operating costs, but over the years that approach was replaced with other payment mechanisms. The report states that between 2010 and 2022, the MEI increased by 23% cumulatively, while the physician fee schedule increased only 6% during that time. Further, the MEI is projected to grow by 3.9% in 2023 and 2.9% in 2024. To address this, MedPAC recommended that the payment rate for physicians and other healthcare practitioners should be increased in 2024 by 50% of the projected increase in the MEI. That recommendation was not adopted by CMS in the Final Rule, because Congressional intervention is required to remove the budget neutrality requirement.

The 2023 Medicare Trustees Report similarly noted concern with the current payment levels for physicians, stating that physician payment amounts "do not vary based on underlying economic conditions, nor are

they expected to keep pace with the average rate of physician cost increases. These rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. … If the health sector cannot transition to more efficient models of care delivery and if the provider reimbursement rates paid by commercial insurers continue to be based on the same negotiated process used to date, then the availability, particularly with respect to physician services, and quality of health are received by Medicare beneficiaries would, under current law, fall over time compared to that received by those with private health insurance."

There has been a bill introduced in Congress that would be at least a first step in ending the trend of conversion factor reductions. In April 2023, the Strengthening Medicare for Patients and Providers Act (H.R. 2474) was introduced that would adjust the conversion factor each year by a percentage equal to the MEI, starting in 2024. The bill has bipartisan support, with 56 cosponsors currently. While the legislature is currently focused on appropriation bills that must be passed by November 17 to avoid a government shutdown, there will continue to be significant pressure from the medical community and the general public to ensure that physicians receive adequate Medicare reimbursement to cover the costs of operating their practices. Lobbying efforts by the AMA, Medical Group Management Association, and others has intensified since the Final Rule was published. It is crucial for the Medicare payment system to reflect the economic reality of practice operating expenses, which the current budget neutrality requirements do not allow.

JTaylor's healthcare consulting team includes a group of professionals who specialize in physician practice dynamics, as well as individuals who focus on strategy and operations. If you are interested in finding out how the 2024 MPFS Final Rule will impact reimbursement for your practice, with its unique services and payer mix, we can help. Our team can also support you from a strategic perspective as you plan for impact of these rules, including the impact of reduced reimbursement. To find out more or to contact a member of our team, please visit our website. We will continue to monitor developments related to legislative activity impacting the healthcare industry.

Sources:

- Center for Medicare and Medicaid Services. (November 2, 2023.) Federal Register (unpublished). *Medicare and Medicaid Programs: Calendar Year 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; etc*. https://public-inspection.federalregister.gov/2023-24184.pdf
- Center for Medicare and Medicaid Services. (November 3, 2023.) *Fact Sheet: Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule.* https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule
- Center for Medicare and Medicaid Services. (November 2, 2023.) *Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule – Medicare Shared Savings Program Fact Sheet*. https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule-medicare-shared-savings-program
- Congressional Research Service. (September 26, 2023.) *Medicare and Budget Sequestration*. https://crsreports.congress.gov/product/pdf/R/R45106
- American Medical Association. (November 6, 2023.) *The real cost of the 2024 Medicare physician fee schedule with Jason Marino.* https://www.ama-assn.org/practice-management/medicare-medicaid/real-cost-2024-medicare-physician-fee-schedule-jason-marino
- American Medical Association. (November 6, 2023.) *The physician shortage crisis is here – and so are bipartisan fixes.* https://www.ama-assn.org/practice-management/sustainability/physician-shortage-crisis-here-and-so-are-bipartisan-fixes
- Medicare Payment Advisory Commission. (March 15, 2023.) *March 2023 Report to the Congress: Medicare Payment Policy*. March 15, 2023. https://www.medpac.gov/document/march-2023-report-to-the-congress-medicare-payment-policy/
- Library of Congress. H.R. 2474 – *Strengthening Medicare for Patients and Providers Act.* https://www.congress.gov/bill/118th-congress/house-bill/2474?overview=closed