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The Centers for Medicare and Medicaid Services (CMS) recently released the Calendar Year (CY) 2024 Medicare Physician Fee Schedule (MPFS) Proposed Rule. The most concerning provision in the proposed rule is a conversion factor that reflects a 3.36% decrease from the CY 2023 rate. Industry groups continue to lobby for a legislative fix, claiming that the budget neutrality rules that govern physician reimbursement result in reimbursement that is inadequate as costs of running a practice continue to rise. Providers maintain that this reimbursement structure is unsustainable and will have a negative impact on Medicare patients' access to care. Below is a recap of the key provisions contained in the proposed rule, other relevant factors that will impact Medicare reimbursement, and current activity in the push for legislative changes.

Conversion Factor

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). Historically, the conversion factor did not change significantly from year to year, given that CMS is required by law to maintain budget neutrality. However, the conversion factor decreased substantially 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. Congress intervened and staved off what at one time was expected to be a 10.2% reduction. Similarly, the conversion factor for 2022 was set to be significantly reduced, but 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 3.36% decrease in the conversion factor based on the CY 2024 MPFS Proposed 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	$ 32.3433	*(2.2%)*	1.25%	$ 32.7476	*(3.4%)*	$ 20.4370	*(3.3%)*
Cumulative Change: 2019 - 2024	$ (3.70)	*(10.3%)*		$ (3.29)	*(9.1%)*	$ (1.84)	*(8.2%)*

Sequestration Impact

The rates reflected above do not reflect the 2% Medicare sequestration cut stemming from a 2011 law 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. 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. The omnibus bill passed by Congress at the end of 2022 postpones these spending cuts until at least 2025. Without that bill, all Medicare payments would be subject to an additional 4% cut. While this means 2024 pay rates will not be impacted, the pay cut would apply in 2025 without further legislative intervention.

Other Provisions

The 2024 MPFS Proposed 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

Under the Proposed Rule, 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.

The addition of this new code contributes significantly to the estimated overall impact of the Proposed Rule 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). The 2022 MPFS final rule required that beginning in 2023, such visits must be billed under the provider number of the individual providing more than half of the total visit time. However, the 2023 MPFS Final Rule delayed implementation of that provision until 2024, and instead extended the billing approach utilized in 2022 that allows a choice in determining which clinician provided the "substantive portion" of the visit. The CY 2024 Proposed Rule once again delays implementation of the changes through at least December 31, 2024, extending the current approach. Under this framework, if the physician performs the history, physical exam, or medical decision-making, or spends more than half the total time with the patient, the visit may be billed under the physician's provider number. Otherwise, it must be billed under the NPP's number, which results in a 15% reduction to the reimbursement rate.

Behavioral Health Services

The Proposed 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 that meet applicable requirements can also enroll in Medicare as MHCs and bill for services beginning January 1, 2024. 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 Proposed Rule would also allow 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 proposing a new HCPCS code for crisis psychotherapy services furnished 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 would 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.

In the Proposed Rule, CMS acknowledges 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. CMS proposes to apply an adjustment of 19.1% to the work RVUs for psychotherapy codes payable under the MPFS, essentially incorporating the E/M complexity add-on code work RVUs. Given the significance of this adjustment, CMS proposes that this change be implemented over a four-year period.

Telehealth Services

The CAA 2023 included several provisions extending telehealth flexibilities that were established during the COVID pandemic. The Proposed 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.

CMS is proposing to pay for telehealth services provided to patients in their homes at the non-facility MPFS rate, while services provided to patients in other settings would continue to be paid at the MPFS facility rate. The Proposed Rule would remove the telehealth frequency limitations for inpatient hospital visits, nursing facility visits, and critical care consultation services through 2024.

The Proposed Rule would allow physicians to 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.

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 proposes to remove 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.

Caregiver Training Services

CMS proposes to provide payment to practitioners who train caregivers to support patients with certain diseases or illnesses in carrying out a treatment plan. The Proposed Rule defines a caregiver as a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition. Further, this would be an individual who assists or acts as a proxy for a patient with an illness or condition of short or long-term duration, is involved on an episodic, daily, or occasional basis in managing a patient's complex health care and assistive technologies at home, and helps navigate the patient's transitions between care settings. Training could be provided to more than one caregiver for a single patient. The treating practitioner must obtain the patient's consent for the caregiver to receive caregiver training services.

Health-Related Social Needs

The Proposed Rule contains provisions that would pay 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. To qualify for payment, the SDOH Risk Assessment must be furnished on the same day as an E/M visit, as it should influence the diagnosis and treatment plan.
- **Community Health Integration** – These are services performed by certified or trained auxiliary personnel, incident to the professional services and under the general supervision of the billing practitioner, that address unmet SDOH needs. These services could be furnished monthly, as medically necessary, following an initial E/M visit.

- **Principal Illness Navigation** – 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. Most often, this would be needed when a patient is diagnosed with cancer or another severe, debilitating illness that requires access to and coordination of care from multiple specialists or service providers.

Dental and Oral Health Services

The 2023 MPFS Final Rule expanded coverage for dental services inextricably linked to other covered medical services. That rule included a provision that dental exams and necessary treatments prior to treatment for head and neck cancers would qualify for Medicare payment beginning in 2024. The CY 2024 Proposed Rule seeks to implement that provision. Additionally, payment would be permitted for certain dental services inextricably linked to the following medical services, when used to treat cancer:

- Chemotherapy;
- CAR-T Cell therapy; and
- Administration of high-dose bone-modifying agents (antiresorptive therapy).

Specialty Impact

CMS performed an analysis to estimate the ranges of impact for practitioners within each specialty, based on 2022 utilization data. According to this analysis, many specialties would see a minimal change (plus or minus 1%) in Total RVUs as a result of the provisions reflected in the Proposed Rule, as summarized below:

Specialty	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Geriatrics	0%	1%	0%	1%
Internal Medicine	0%	1%	0%	1%
Neurology	0%	0%	0%	1%
Obstetrics/Gynecology	0%	1%	0%	1%
Pediatrics	0%	1%	0%	1%
Urology	0%	0%	0%	1%
Cardiology	0%	0%	0%	0%
Gastroenterology	0%	0%	0%	0%
Interventional Pain Mgmt	0%	0%	0%	0%
Multispecialty Clinic/Other Phys	0%	0%	0%	0%
Other	0%	-1%	0%	0%
Otolaryngology	0%	0%	0%	0%
Podiatry	0%	0%	0%	0%
Pulmonary Disease	0%	0%	0%	0%
Allergy/Immunology	0%	-1%	0%	-1%
Critical Care	-1%	0%	0%	-1%
Dermatology	0%	0%	0%	-1%
General Surgery	-1%	-1%	0%	-1%
Hand Surgery	-1%	0%	0%	-1%
Independent Laboratory	-1%	-1%	0%	-1%
Infectious Disease	-1%	0%	0%	-1%
Nephrology	-1%	0%	0%	-1%
Neurosurgery	-1%	0%	0%	-1%
Ophthalmology	0%	0%	0%	-1%
Orthopedic Surgery	-1%	0%	0%	-1%
Physical Medicine	0%	0%	0%	-1%
Plastic Surgery	-1%	-1%	0%	-1%
Portable X-Ray Supplier	0%	0%	0%	-1%

For these specialties, the most significant impact of the Proposed Rule 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.

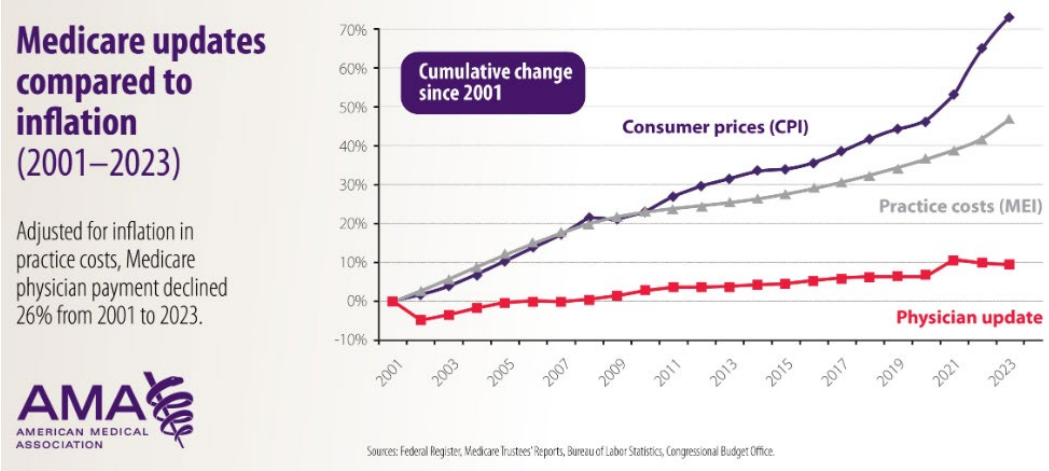
Specialty	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Endocrinology	1%	1%	0%	3%
Family Practice	2%	2%	0%	3%
Clinical Psychologist	1%	0%	0%	2%
Clinical Social Worker	2%	0%	0%	2%
General Practice	1%	1%	0%	2%
Hematology/Oncology	1%	0%	0%	2%
Nurse Practitioner	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 would 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%
Radiology	-1%	-2%	0%	-3%
Vascular Surgery	0%	-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%
Diagnostic Testing Facility	0%	-2%	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%
Physical/Occupational Therapy	-1%	-2%	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 is advocating for an overhaul of the Medicare payment system to something that would provide more financial stability and predictability. They point out that "Medicare physician payment has effectively been cut 26%, adjusted for inflation, from 2001-2023," using the graphic below to emphasize the point:



The AMA claims that "the discrepancy between what it costs to run a physician practice and actual payment combined with the administrative and financial burden of participating in Medicare is encouraging market consolidation and threatens to drive physicians out of rural and underserved areas." They are 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.

In its March 2023 report to Congress, the Medicare Payment Advisory Commission (MedPAC) noted that the Medicare Economic Index (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 is a measure of practice cost inflation that was established decades ago to estimate changes in operating costs and establish corresponding Medicare physician payment updates, 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.

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."

It appears that Congress is starting to listen. In April 2023, a bill 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 33 cosponsors already. To this point the bill has not gained traction, with the legislature

currently focused on appropriation bills that must be passed by September 30 to avert a government shutdown. However, 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. Otherwise, there is legitimate concern that over time it will be harder for Medicare beneficiaries to access care, as physicians would become more reliant on patients with private insurance to maintain viable practices.

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 Proposed Rule would 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 proposed 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

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