Medicare 2024 Proposed Physician Payment Policies Released

On July 13, 2023, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2024 Medicare Physician Fee Schedule (PFS) proposed rule. The rule will be posted in the Federal Register no later than August 7, 2023. Comments will be accepted until September 11, 2023.

CY 2024 Conversion Factor (CF)

- The 2024 proposed **physician CF is $32.7476,** a decrease of approximately 3.36% from the 2023 CF of $33.8872.
- The proposed CF update is based on three factors:
    - A statutory 0% update scheduled for the PFS in CY 2024 under MACRA;
    - An approximately 2.17% decrease due to a budget neutrality adjustment, of which 90% can be attributed to the implementation of complexity add on code G2211 and the remaining 10% can be attributed to other proposed valuation changes such as the Year 3 update to clinical labor pricing and/or the proposed adjustment to certain behavioral health services.
    - The expiration of 1.25% of the 2.5% positive adjustment to the CF the Congress provided for in CY 2025, which it reduced to 1.25% for CY 2024.
- Congressional action will be needed to avert or mitigate additional cuts facing physicians in CY 2024

Specific to policies and codes pertaining to Echocardiography

- Non-facility payment rates are proposed to drop between 3% to 6% relative to 2023 prices for many echocardiography services. This is driven by the proposed 3.36% reduction in the physician conversion factor and clinical labor updates.
- CMS is proceeding with the third year of phasing in the updated clinical labor prices based on the CY 2023 prices they approved. No new pricing information was submitted for CY 2024.
- Intraoperative epicardial cardiac services (CPT codes 7X000-7X003) were valued for CY2024 and proposed by CMS at lower than RUC values. These services were benchmarked against transesophageal echocardiography codes (CPT codes 93312 – 93316).
- Overall Impact of Proposed Rule on Cardiology is anticipated to be 0%
    - Actual payment rates are affected by a range of proposed policy changes related to physician work, practice expense (PE), and malpractice Relative Value Units (RVUs).
    - CMS summarizes the aggregate impact of these changes in Table 104 in the proposed MPFS rule. Individual practices will vary based on service mix, the table provides insight into the overall impact of the policies in the rule for a specific specialty.
    - Specialty impacts range from -4% for interventional radiology to +3% for Endocrinology and Family Medicine. Note, changes to the CF are not reflected in the impact table.

Practice Expense Data Collection/Methodology

CMS continues to solicit feedback from and engage with stakeholders on how to best review or update their current PE methodology. They are looking for long-term policies or methods that will consider the feasibility of frequent or regular updates. CMS acknowledges the AMA PPIS data collection effort but is

asking for comment on whether contingencies or alternatives may need to be considered if there was data lacking during the collection effort. Specifically, CMS is requesting feedback on:

- Whether they should consider aggregating data for certain specialties, and if so what thresholds or methodologies should be employed to establish such aggregations?
- Whether aggregations of services, for the purposes of assigning PE inputs, represent a fair, stable, and accurate means to account for indirect PEs across various specialties or practice types?
- If and how CMS should balance factors that influence indirect PE inputs when these factors are likely driven by a difference in geographic location or setting of care, specific to individual practitioners (or practitioner types) versus other specialty/practice-specific characteristics (for example, practice size, patient population served)?
- What possible unintended consequences may result if CMS were to act upon the respondents' recommendations for any highlighted considerations above?
- Whether specific types of outliers or non-respond bias may require different analytical approaches and methodological adjustments to integrate refreshed data?

Evaluations and Management (E/M)

CMS is proposing to implement a separate add-on payment for healthcare common procedure coding system (HCPCS) code G2211 (*Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed healthcare services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition, or a complex condition*). While this new add-on service contributes to the CF cut, physicians will be able to report this new code. Payment for the physician work of the G2211 add-on code is proposed at $10.81.

CMS believes this add-on code will better recognize the resource costs associated with E/M for primary care and longitudinal care of complex patients. Generally, it will be applicable for outpatient office visits as an additional payment, recognizing the inherent costs clinicians may incur when longitudinally treating a patient's single, serious, or complex chronic condition. It should not be billed with a modifier that denotes an office and outpatient E/M visit that is itself unbundled from another service (e.g., a procedure where complexity is already recognized in the valuation).

Telemedicine

In a positive move, CMS proposes several provisions including allowing telehealth visits to originate at any site in the U.S. (e.g., individual's home), payment for audio-only services, and permanently including Social Determinants of Health Risk Assessments. These are a few of the telehealth-related provisions of the CAA, 2023, including:

- Continued coverage and payment of telehealth services included on the Medicare Telehealth Services List (as of March 15, 2020) until December 31, 2024.
- Audio-only (telephone) CPT codes 99441 - 99443 are telehealth services and will remain actively priced through 2024.

- Payment of telehealth services furnished to people in their homes at the non-facility PFS rate to protect access to mental health and other telehealth services by aligning with telehealth-related flexibilities that were extended via the CAA, 2023.
- Continuing to define direct supervision to permit the presence and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications through December 31, 2024.
- The temporary expansion of the scope of telehealth originating sites for services furnished via telehealth to include any site in the United States where the beneficiary is located at the time of the telehealth service, including an individual's home;
- The continued payment for telehealth services furnished by rural health clinics (RHCs) and Federally Qualified Health Centers (FQHCs) using the methodology established for those telehealth services during the PHE;
- Direct Supervision via Use of Two-way Audio/Video Communications Technology - In the March 31, 2020, COVID-19 IFC, CMS changed the definition of "direct supervision" during the Public Health Emergency (PHE) for COVID-19 as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence. CMS is soliciting comments on whether CMS should consider extending the definition of direct supervision to permit virtual presence beyond December 31, 2024. Specifically, CMS is interested in input on potential patient safety or quality concerns when direct supervision occurs virtually; for instance, if virtual direct supervision of certain types of services is more or less likely to present patient safety concerns, or if this flexibility would be more appropriate for certain types of services, or when certain types of auxiliary personnel are performing the supervised service.

Split/Shared Visits

CMS proposes to delay the implementation of the definition of the "substantive portion" as more than half of the total time through at least December 31, 2024. Instead, CMS will maintain the current definition of substantive portion for CY 2024 that allows for use of either one of the three key components (history, exam, or medical decision making) or more than half of the total time spent to determine who will bill for the visit.

Updating the Medicare Economic Index (MEI) for CY 2024

In its CY 2023 PFS rulemaking, CMS finalized its proposal to rebase and revise the MEI to reflect more current market conditions faced by physicians in providing services. CMS will use a 2017-based MEI that relies on a methodology that uses publicly available data sources for input costs that represent all types of physician practice ownership, not limited to only self-employed physicians. In light of the AMA's intended data collection efforts soon on physician practice expenses and because the methodological and data sources changes to the MEI will have significant impact on PFS payments, CMS proposes to

delay implementation of the finalized 2017-based MEI cost weights and not incorporate the new cost weights for CY 2024 until AMA has completed its data collection.

Health Equity

CMS is proposing coding and payment for several new services to help underserved populations. We applaud the Administration's commitment to advance health equity and expand access to critical medical services. This ongoing effort to implement and operationalize these policies will support people who are disadvantaged or underserved and provide the care and support those patients require.

Quality Payment Program (QPP)

CMS also proposes to make adjustments to the Merit-based Incentive Payment System (MIPS), including:

- Increasing the quality measure data completeness threshold from 70% to 75% for three years (performance years 2024-2026) and to 80% for 2027-2029.
- Requiring for the 2024 performance year a continuous 180-day performance period for the Promoting Interoperability performance category. Currently, the performance period is a continuous 90-day period.
- Increasing the performance threshold for the 2024 performance year to avoid a penalty from 75 points to 82 points. Providers unsuccessfully participating in the QPP will receive a payment cut of 9% in 2026.

CMS is proposing five new Merit-based Incentive Payment System Value Pathways (MVPs) for CY 2024, including, "Focusing on Women's Health," "Quality Care for the Treatment of Ear, Nose, and Throat Disorders," "Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV," "Quality Care in Mental Health and Substance Use Disorders," and "Rehabilitative Support for Musculoskeletal Care."

CY 2024 Medicare Proposed Physician Payment Charts
Comparison of Final CY 2023-Proposed 2024 National MPFS Rates for Echocardiography
Comparison of CY 2023-CY 2024 Proposed National HOPPS (APC) Rates for Echocardiography

CMS Proposed Rule and Fact Sheets
2024 Medicare Physician Fee Schedule Proposed Rule
2024 Medicare Physician Fee Schedule Proposed Rule Fact Sheet
2024 Quality Payment Program Fact Sheet