



Insight

CMS' New Rules on Physician Reimbursement

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Executive Summary

- The Centers for Medicare and Medicaid Services (CMS) released its Calendar Year 2024 Medicare Physician Fee Schedule final rule, containing a variety of payment and policy updates for physician services, which will result in payment rate decreases of 1.25 percent in 2024 for practitioners, with total payments to providers in 2024 estimated to remain constant at \$89 billion.
- Evaluation and management visit payment increases, as well as new marriage and family therapy and mental health counselor benefits, are responsible for the decreased payment rates due to budget neutrality rules.
- CMS is also implementing several social determinants of health (SDOH) policies, including separate payments for services intended to address SDOH difficulties faced by patients as well as increase the availability of patient navigation services.

Introduction

The Centers for Medicare and Medicaid Services (CMS) [recently released](#) its Calendar Year (CY) 2024 Medicare Physician Fee Schedule (PFS) final rule. This rule finalizes payment and policy updates to physician payments as well as other Medicare Part B issues. The CY 2024 rule contains a wide variety of updates and responses to earlier requests for comment. The major updates summarized below include payment updates for physicians as well as new policies regarding evaluation and management (E/M) services, new behavioral health services, social determinants of health (SDOHs), telehealth services, the Inflation Reduction Act (IRA), and changes to the Medicare Shared Savings Program, among other changes.

Payment Rates

CMS will reduce overall payment rates under the PFS by 1.25 percent in CY 2024 compared to CY 2023. The PFS conversion factor itself will be reduced by 3.4 percent from CY 2023, from \$33.89 to \$32.74 in CY 2024. The decrease in the conversion factor is due in part to the expiration of a one-year 2.50 percent increase in PFS payment amounts specified in the Consolidated Appropriations Act of 2023 (CAA 2023) provided for CY 2023. CAA 2023 also provides for a 1.25 percent increase in the conversion factor, but this is balanced out against a negative 2.18 percent budget neutrality adjustment to relative value units (RVUs). RVUs are units assigned to services to represent the work and expense involved in a given service, and are then multiplied by the conversion factor to produce a payment amount for the provider. CMS attributes roughly 90 percent of this negative budget neutrality adjustment to separate add-on payments being implemented for E/M, behavioral health services, and clinical labor services. CMS states that certain practices, especially primary care and other direct patient care practices, will see payment increases. Overall, CMS estimates total payments for providers in CY 2024 at under \$89 billion, virtually unchanged from CY 2023.

Evaluation and Management Visits

CMS is creating an add-on code for E/M visits to recognize the resource costs associated with these visits for primary and longitudinal care. As noted above, this add-on code has negative impacts for all other CY 2024 PFS payments. To reduce the impact of this add-on, CMS has excluded E/M visits for procedures or other services not focused on longitudinal care from receiving the add-on payment.

CMS is also clarifying that for split E/M visits in which two or more practitioners share time with the patient, the definition of “substantive portion” of a split visit means more than half of the total time or the more substantive part of medical decision making.

Behavioral Health Services

In accordance with CAA 2023, CMS is implementing coverage and payment for marriage and family therapists (MFTs) and mental health counselors (MHCs), as well as adding addiction counselors to enroll in Medicare as MHCs. Additionally, CMS is creating new codes under the PFS for psychotherapy for crisis services in a non-hospital, office, or institutional setting.

The CY 2024 final rule allows for Health Behavioral Assessment and Intervention (HBAI) services to be billed by clinical social workers, MFTs, and MHCs. Of note, CMS is increasing the valuation for timed behavioral health services in this rule by increasing the work RVUs for psychotherapy codes, as well as applying this adjustment to psychotherapy codes that billed to an E/M visit and HBAI codes. Additionally, MFTs and MHCs will now be allowed to provide services in Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) and CMS is reducing requirements for nurse practitioners to be able to practice in FQHCs and RHCs.

Social Determinants of Health Policy

CMS will also now pay separately for Community Health Integration (CHI), SDOH Risk Assessment, and Principal Illness Navigation (PIN) services to account for services involving health care support staff, including community health workers, care navigators, and peer support specialists. CHI services are meant to address unmet SDOH needs that will affect the diagnosis or treatment, while PIN services are to help Medicare beneficiaries with high-risk conditions (e.g., dementia, HIV/AIDS, or cancer) connect with clinical and support resources. CMS states the goal of these services is to provide Medicare beneficiaries with access to cancer and other disease navigation services.

CMS is also establishing coding and payments for SDOH risk assessments, including adding the SDOH risk assessment as an “optional, additional element” during an annual wellness visit with an additional payment and no coinsurance or copayment by the beneficiary. These SDOH policies also apply to RHCs and FQHCs.

Telehealth Services

As required by CAA 2023, CMS is extending many of the COVID-19 public health emergency telehealth flexibilities for at least another year. This includes: allowing telehealth visits to originate from anywhere the beneficiary is located in the United States; the expanded definition of telehealth practitioners to include occupational therapists, qualified physical therapists, qualified speech-language pathologists, and qualified audiologists; payment for telehealth services furnished by RHCs and FQHCs; delaying the requirement for an in-

person evaluation with a provider before initiating mental health telehealth services; and continued coverage of telehealth services included in the Medicare Telehealth Services List. CMS will continue allowing teaching physicians to use audio/video technology to be present when a resident furnishes telehealth services, and additionally will allow opioid treatment programs to provide assessments via audio-only equipment for telehealth services. CMS will also be paying non-facility PFS rates (meaning the provider will receive a higher payment) for telehealth services furnished to beneficiaries in their homes.

Providers will be able to continue to bill for physical therapy, occupational therapy, speech-language pathology, diabetes self-management training (DSMT), and medical nutrition therapy services provided via telehealth. CMS is proposing to allow all DSMT services to be furnished via telehealth and is creating billing rules for telehealth DSMT services that more closely align to billing rules for in-person DSMT services.

Inflation Reduction Act

CMS is finalizing the codification of several provisions of the IRA, including: payment limits for new biosimilars furnished on or after July 1, 2024; changes to regulatory text regarding payment limits for biosimilars related to the average sales price; changes to regulatory text ensuring beneficiary coinsurance for a Part B drug is based on the inflation-adjusted payment amount; and finalizing codification of the provision limiting coinsurance on insulin to \$35 for a month's supply.

Medicare Shared Savings Program

CMS is establishing a new Medicare Clinical Quality Measure for accountable care organizations (ACOs) and will align the Shared Savings Program and Merit-based Incentive Payment System Promoting Interoperability program requirements beginning January 1, 2025. CMS will apply a cap to risk score growth in an ACO's regional area, make risk adjustment methodology consistent between benchmark and performance years, and eliminate negative regional adjustment to the benchmark year. CMS will also add an additional step to the beneficiary assignment process to allow more beneficiaries to be assigned to nurse practitioners, physician assistants, and clinical nurse specialists.

Miscellaneous

CMS is permitting Part A and Part B payment for certain dental services, including: necessary dental and oral examinations performed prior to diagnostic treatment services, elimination of oral or dental infection prior to treatment services, and addressing dental and oral complications as a result of head and neck cancer treatments. Payment will also be allowed for dental and oral services inextricably linked to certain services used to treat cancer.

CMS is establishing payments for caregiver training done by practitioners, including physicians, non-physician practitioners, and therapists for certain severe diseases or illnesses (e.g., dementia).

The Medicare Diabetes Prevention Program (MDPP) Expand Model's flexibilities are being extended, allowing MDPP suppliers to offer virtual MDPP services through 2027. CMS is also expanding diabetes screenings.

CMS is continuing the practice of notifying prescribers of non-compliance in electronic prescribing of controlled substances, which in serious cases can result in referral to law enforcement or revocation of billing privileges. Additionally, CMS is clarifying how compliance is determined and updating compliance exemptions

for emergency and extraordinary circumstances.

CMS is maintaining additional payments for COVID-19 vaccine delivery in the home and extending this additional payment to the pneumococcal, influenza, and hepatitis B vaccines when provided in the home. Payments for all four vaccines will be identical.