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MPFS Final Rule Cuts Physician Payments

On November 2, 2023, the Centers for Medicare & Medicaid Services (CMS) released its finalized Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2024. While the finalized fee schedule cuts payments to physicians, there are a number of other (more positive) provisions in the final rule. This Health Capital Topics article explores the various changes and updates included in the MPFS final rule.

Payment Rate Updates for MPFS

The overall MPFS payment rates will be reduced in CY 2024 by 1.25%.[1] The conversion factor will decline by $1.15, to $32.74 (a nearly 3.4% reduction from 2023's conversion factor of $33.89),[2] the fourth straight year that physician payment rates have experienced a decrease. The conversion factor converts a relative value unit (RVU) – a geographically-adjusted number that represents the amount of resources required to perform each procedure listed in the MPFS – into a payment amount for a given service.[3] This conversion factor is updated yearly by a formula that takes into account: (1) the previous year's conversion factor; (2) the estimated percentage increase in the Medicare Economic Index (MEI) for the year (which accounts for inflationary changes in office expenses and physician earnings); and, (3) an update adjustment factor.[4] All physician services, except anesthesia services, use a single conversion factor.[5] The CY 2024 conversion factor decrease is the result of: a 0% statutory update; a -2.18% budget neutrality adjustment; and a "funding patch" included in the *Consolidated Appropriations Act of 2023* (CAA).[6]

Changes to the Medicare Shared Savings Program (MSSP)

CMS finalized a number of changes to the Medicare Shared Savings Program (MSSP) in the MPFS final rule.[7] For performance year 2024 and following years, CMS established a new option for reporting quality measures: Medicare Clinical Quality Measures (CQMs) for Accountable Care Organizations Participating in the MSSP.[8] CMS intends for this new data collection type to act as a transitional step in "helping ACOs build the infrastructure, skills, knowledge, and expertise necessary to report all-payer/all-patient" CQMs[9] and moving ACOs "toward digital measurement of quality."[10]

CMS also finalized changes to ACO financial benchmarking methodologies.[11] Beginning January 1, 2024, CMS will: (1) cap the risk score growth in an ACO's regional area of service; (2) apply the same methodology for risk adjustment to both the performance and benchmark years; and (3) eliminate any overall regional adjustment that may be negative for the benchmark, which would aim to encourage the participation of ACOs serving high-cost, medically complex beneficiaries.[12] The aim of changing the methodology for financial benchmarking is to encourage ACOs that serve complex populations to participate in the MSSP.[13]

CMS also finalized methodology changes for beneficiary assignment that would promote access to accountable care for beneficiaries who rely on nurse practitioners, clinical nurse specialists, and physician assistants for their primary care needs.[14] The change would place more importance on the role of clinical nurse specialists, nurse practitioners, and physician assistants in their delivery of primary care services.[15]

Telehealth Changes

CMS is finalizing the implementation of multiple telehealth-related provisions included in the 2023 CAA, including:

(1) The temporary expansion of the scope of originating telehealth sites (for any services which may be furnished via telehealth) to include any site in the nation where the beneficiary is located at the time when services rendered;

(2) The expansion of the current definition of a telehealth practitioner to include qualified audiologists, speech-language pathologists, physical therapists, and occupational therapists;

(3) The continued payment for services furnished through telehealth by federally qualified health centers (FQHCs) and rural health centers (RHCs) using the same methodology which was established during the COVID-19 public health emergency (PHE);

(4) Delaying requirements for in-person visits with a practitioner or provider within six months before initiating telehealth services related to mental health; and

(5) The continuation of payment and coverage for telehealth services included on the Medicare Telehealth Services List.[16]

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All these telehealth flexibilities will continue at least until the end of 2024.[17] However, one change that will occur, beginning in CY 2024, is that telehealth services rendered to Medicare beneficiaries in their homes will be paid at the lower, non-facility MPFS rate (currently, they are paid at the higher, facility MPFS rate).[18]

Other Provisions

CMS is finalizing their proposal for payments to practitioners that train caregivers to assist patients with certain illnesses or diseases in carrying out plans of treatment.[19] These services will be paid for by Medicare when furnished by a physician, non-physician practitioner, or therapist.[20] Medicare will also advance their health equity efforts by separately paying for services related to social determinants of health risk assessments, community health integration, and principal illness navigation.[21] Payments will include and account for resources when clinicians work alongside healthcare support staff (such as care navigators, peer support specialists, and community health workers) to furnish care.[22]

CMS finalized the implementation of a separate payment for healthcare common procedure coding system (HCPCS) add-on code G2211: "*visit complexity inherent to evaluation and management [E/M] 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*."[23] The add-on code, for which providers can start billing beginning January 1, 2024, will help providers better recognize the costs related to evaluation and management (E/M) visits for longitudinal and primary care, which necessarily relies on the long-term relationship between the patient and the physician.[24] The add-on payment aims to better recognize clinicians' costs related to a patient's ongoing care for a serious or complex condition.[25] CMS provided a situational example of when the code may be used: "a patient has a primary care practitioner that is the continuing focal point for all healthcare services [i.e., has a long-term relationship with the provider], and the patient sees this practitioner to be evaluated for sinus congestion."[26] CMS stated that

> "the inherent complexity that this code (G2211) captures is not in the clinical condition itself—sinus congestion—but rather the cognitive load of the continued responsibility of being the focal point for all needed services for this patient…The primary care practitioner must decide—what course of action and choice of words in the visit itself, would lead to the best health outcome in this single visit, while simultaneously building up an effective, trusting longitudinal relationship with this patient for all of their primary health care needs."[27]

CMS also revised the definition of "substantive portion" of a shared or split E/M visit. E/M codes capture time the healthcare provider spends in a hospital or other facility setting (not in the office) "evaluating or managing a patient's health."[28] E/M visits are often performed by both a physician and an advanced practice clinician (APC), such as a nurse practitioner or a physician assistant. Who can bill for the time spent evaluating and managing a patient is important because only one provider can bill for the service, and Medicare reimburses physicians a higher amount for E/M visits than APCs. CMS requires that the provider who performs a "substantive portion" of a shared (or split) E/M visit bill for their time (at their rate).[29] The final rule revised "substantive portion" to be defined as over half of the total amount of time spent with a physician or non-physician practitioner that is performing the shared or split visit, or a major portion of the decision making.[30] Previously, the term was defined "as one of the following: either one of the three key E/M elements (that is, history, exam, or [medical decision making]) or more than half of total time."[31]

Comments from Stakeholders

Industry trade associations strongly condemned the cuts to physician payments contained in the MPFS final rule. The Medical Group Management Association (MGMA) implored Congress to act to avoid cuts to physician payments, stating that the reduction would be increasing "the gap between physician practice expenses and reimbursement rates, and dangerously impeding beneficiary access to care."[32] The President of the American Medical Association (AMA) stated that "the Medicare physician payment schedule released today is an unfortunate continuation of a two-decade march in making Medicare unsustainable for patients and physicians."[33] The AMA and other physician groups criticized the rule before it was even finalized, taking their case to Congress to argue that Medicare physician fees should not be reduced.[34]

However, some associations did praise other provisions. The National Association of ACOs (NAACOS) President and CEO Clif Gaus stated that the "NAACOS appreciates that CMS continues to support the growth of value-based care."[35] Gaus also expressed NAACOS's support of CMS's leadership to "create stronger pathways for clinicians and health systems who want to provide higher quality, more cost effective, coordinated care for patients."[36]

Conclusion

According to CMS Administrator Chiquita Brooks-LaSure, "CMS remains steadfast in [its] commitment to supporting physicians and ensuring that people with Medicare have access to the care they need to stay healthy as well as navigate health conditions they are facing."[37] However, providers believe that cuts to physician payments will in fact have the opposite effect – reduced patient access to care. On November 8, 2023, after provider trade associations lobbied for the government to override the MPFS final rule cuts, the Senate Finance Committee approved legislation which included language that scaled back the Medicare payment cuts for physicians.[38] While the legislation would not completely reverse the cut, it would soften the impact by replacing the 3.4% reduction with a 2.15% cut.[39] The effect on physician payment rates will be determined by CMS once the legislation is enacted.[40]

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