National Rural Health Association

Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule

Last week, the Centers for Medicare and Medicaid Services (CMS) released its final rule for the CY 2024 Medicare Physician Fee Schedule (MPFS). This rule includes a significant decrease in physician payments, new Medicare benefits, and other policy changes. For more information, see the summary below or find CMS' fact sheet here. If you have any questions, contact NRHA's Regulatory Affairs Manager, Alexa McKinley (amckinley@ruralhealth.us).

Key provisions include:

Payment update. CMS is finalizing its proposal to cut physician payments by 3.4% for CY 2024. The final CY 2024 conversion factor is $32.74. NRHA is disappointed to see this decrease finalized and urged CMS to explore its authority to avoid this payment cut in our comment letter.

CMS is also finalizing a new complexity add-on code, G2211, to better account for the added costs and resources associated with providing primary and longitudinal care to highly complex patients. G2211 will be added to evaluation and management (E/M) visits beginning January 1, 2024.

Telehealth. CMS is finalizing an extension of several telehealth flexibilities, including:

- **Paying providers the higher non-facility PFS rate for telehealth services furnished to beneficiaries in their homes** to protect access to these important services.
- **Extending the following telehealth flexibilities through December 31, 2024**:
    - Removing originating site requirements to allow beneficiaries to use telehealth services in their home and other non-clinical locations;
    - Expanding the list of practitioners eligible to furnish telehealth services to include physical therapists, speech-language pathologists, and audiologists;
    - Continuing payment for telehealth services furnished by rural health clinics (RHCs) and federally qualified health centers (FQHCs);
    - Delaying the requirement for an in-person visit with the physician or practitioner within six months prior to initiating mental health telehealth services; and
    - Coverage and payment for telehealth services included on the Medicare Telehealth Services List.
- **Continuing to define direct supervision to permit the presence and immediate availability of the supervising practitioner with audio/video technology through December 31, 2024.** This does not include audio-only.

Split or shared E/M visits. CMS put forth a new policy for billing for split or shared E/M visits in the CY 2022 PFS rule. The new policy states that the practitioner who provides a "substantive portion", or more than half, of the services must bill for the visit. CMS delayed implementation of this policy until January 1, 2024, in the CY 2023 rule. In this final rule, CMS is further revising its policy so that "substantive portion" means more than half of the total time spent by the physician or nonphysician practitioner performing the split (or shared) visit, or a substantive part of the medical decision making. This definition will apply beginning in 2024. NRHA applauds CMS for this change as we have advocated for a definition to include medical decision making during the last two rulemaking cycles.

Addressing SDOH. CMS recognizes that providers expend more time and resources on patients when addressing SDOH. CMS is finalizing new codes to better recognize when members of an

interdisciplinary care team, including community health workers (CHWs) are involved in treating beneficiaries. This includes:

- Two new G codes describing **community health integration services** performed by certified or trained auxiliary personnel, such as CHWs, incident to the professional services and under the general supervision of the billing practitioner.
- **SDOH risk assessment G code** to separately identify and value a SDOH risk assessment that is furnished in conjunction with an E/M visit. This code would better account for the time and work involved in administering a SDOH risk assessment that is medically reasonable and necessary in relation to an E/M visit.
- **New codes for Principal Illness Navigation (PIN) services** to reflect when a patient navigator or certified peer specialist is involved in a beneficiary's health care navigation as part of a treatment plan for a serious illness. PIN services reflect the social, rather clinical, aspects of patient navigation.

RHC and FQHC policies. CMS is finalizing the following policies for RHCs and FQHCs:

- **The required level of supervision for behavioral health services is now general, rather than direct, when furnished incident to a physician or non-physician practitioner's services**.
- Including CHI and PIN services as well as remote physiologic monitoring and remote therapeutic monitoring in the general care management HCPCS code (G0511) when these services are provided in an RHC or FQHC.
- As noted above, payment for telehealth services at RHCs and FQHCs will be continued.

Behavioral health. CMS is implementing provisions from the Consolidated Appropriations Act, 2023, regarding behavioral health, including:

- Medicare Part B **coverage for marriage and family therapists (MFTs) and mental health counselors (MHCs).** Beginning in 2024, these practitioners are able to bill for their services without being incident to a physician or other practitioner. Find more on provider enrollment information here.
    - Accordingly, CMS is making corresponding changes to allow MFTs and MHCs to bill for General Behavioral Health Integration codes.
- **Allowing addiction counselors that meet all requirements to be an MHC to enroll in Medicare as an MHC.**
- Creating new HCPCS codes (90839 and 90840) for psychotherapy for crisis services that are furnished at any place of service outside of the office, including at mobile units or in a beneficiary's home. Payment for such services would be at 150% of the PFS rate for non-facility sites.

Dental and oral health services. Beginning in CY 2023, Medicare covers dental services that are inextricably linked to other covered medical services. Now CMS is codifying new scenarios in which Medicare will cover dental care:

- Dental services related to head and neck cancers.
- Dental or oral exams performed as part of a comprehensive workup prior to medically necessary diagnostic and treatment services, to eliminate an oral or dental infection prior to

or during treatment services, and to address dental or oral complications after radiation, chemotherapy, or surgery when treating head and neck cancers.
- Certain dental services inextricably linked to other covered services used to treat cancer prior to or during chemotherapy, CAR-T cell therapy, or antiresorptive therapy.

In February 2024, CMS will accept and consider public submissions for scenarios under which Medicare payment could be made for dental services. These submissions will help inform future rulemaking.

Medicare Shared Savings Program (MSSP). CMS finalized several changes to MSSP, including:

- Establishing a new Medicare Clinical Quality Measure (CQM) for accountable care organizations (ACOs) in the Alternative Payment Model Performance Pathway. Medicare CQMs are meant to serve as a transition collection type to help ACOs build the capacity to report the all-payer and all-patient Merit-Based Incentive Payment System (MIPS).
- Adopting a regional risk score growth cap.
- Amending the beneficiary assignment methodology and the definition of an assignable beneficiary to better account for beneficiaries who receive primary care from nurse practitioners, physician assistants, and clinical nurse specialists.
- Modifying policies around Advance Investment Payments (AIPs) for ACOs. ACOs that are prepared to progress to performance-based risk can advance to two-sided model levels beginning in their third performance year of the agreement period in which they receive AIPs. Additionally, ACOs receiving AIPs can renew their participation agreement early after the second performance year without triggering full recoupment of advance investment payments at that time.