American Academy of Dermatology Association

Policy Analysis: 2024 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule Analysis

On July 13, the Centers for Medicare & Medicaid Services (CMS) released the 2024 Medicare Physician Fee Schedule (PFS) proposed rule, which includes important policy changes to fee-for-service payments and the quality payment program (QPP).

The proposed 2024 Medicare conversion factor would be reduced by about 3.4% from $33.8872 to $32.7476. The reduction to the conversion factor reflects a budget neutrality adjustment of -2.17 %, a 1.25% decrease in the temporary update to the conversion factor provided by the 2023 Consolidated Appropriations Act, 2023 (CAA), and the 0.00% update adjustment factor as established in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). As a reminder, the CAA provided a temporary +2.5% increase to the conversion factor for 2023 and a temporary +1.25% increase to the conversation factor for 2024.

Conversion Factor Breakdown			
Final 2023 Conversion Factor			$33.8872
Conversion Factor before *2023* CAA	- 2.5% (.82651)		$33.0607
2024 RVU Budget Neutrality Adjustment	- 2.17% (0.9783)		
2024 Increase due to the *2023* CAA	+ 1.25% (1.0125)		
2024 Conversion Factor			**$32.7476**

According to the American Medical Association (AMA) specialty impact tables, based off allowed charges, dermatology is expected to face an overall -1.87% payment reduction due to the policy changes in the proposed rule and the conversion factor decrease from 2.5% to 1.25% mandated by the CAA. However, the total impact could differ depending on individual practice mix.

The AADA evaluated the impact on dermatologic codes and estimates a decrease ranging from approximately -1.00 to -4.00% per code. The proposed payment rates for each code reflect the impact of various policy changes related to physician work, practice expense, and malpractice relative value units (RVUs). For example, the punch biopsy code (11104) will see a -3.87% reduction while destruction of benign lesions (17110) will see a -2.80% reduction and a low-level E/M service (99213) will see a -1.56% reduction. Access the AADA's analysis of the top dermatology codes and RVUs for nearly 400 dermatology codes.

The AADA continues to advocate for a permanent fix to the broken Medicare payment system. The decline in Medicare physician payment by 26% from 2001 to 2023 has disproportionately impacted small, independent, and rural practices, and those caring for low-income or historically marginalized patients. With CMS projecting a 4.5% Medicare Economic Index (MEI) increase for 2024 to gauge inflation affecting physicians' practice costs and wages, **the AADA maintains that annual payment cuts have escalated to a critical level, and physicians cannot continue to absorb the costs, ultimately impacting their ability to provide patient care.**

OTHER PROPOSED MEDICARE PFS POLICIES:

Evaluation and Management (E/M) Codes

E/M Add-on Code (G2211)

In the 2021 Medicare PFS Final Rule, CMS finalized Healthcare Common Procedure Coding System (HCPCS) G2211, an add-on code for complex patients that may only be reported with office and outpatient evaluation and management (E/M) codes. CMS assumed that this add-on code would be reported with 90% of office and outpatient E/M, which would result in a redistribution of $3 billion. However, following advocacy from the AADA and the surgical community, Congress suspended the implementation of the G2211 for three years until 2024.

In the 2024 Medicare PFS, CMS is proposing to implement HCPCS Code G2211 with refinements, which would reduce the redistributive impacts of the policy. Specifically, CMS that the add-on code would not be billed with a modifier, modifier 25, that denotes an office and outpatient evaluation management visit that is itself unbundled from another service that is a procedure where complexity is already recognized in evaluation. As a result, CMS reduced the utilization estimate for G2211 to 38% for the first year of implementation. However, CMS projects that when G2211 has been fully integrated into routine billing practices, it is projected to be billed with 54% of all office and outpatient E/M visits.

Medicare Economic Index and AMA Physician Practice Information Survey

CMS is not proposing to incorporate the finalized 2017-based Medicare Economic Index (MEI) cost weights for the Relative Value Units (RVUs) in the Medicare PFS rate setting for 2024, due to the pending completion of the AMA’s Physician Practice Information (PPI) Survey.

As a reminder, the AMA is conducting the PPI Survey to collect data on physician practice expenses. The goal of the survey is to better understand the costs faced by today's physician practices to support physician payment. The survey was last conducted in 2007 and 2008 and is reflective of 2006 data. The AMA contracted with Mathematica, an independent research company, to conduct the study. The AMA says that it plans to share survey data with CMS in 2025 and policy changes would be reflected in the 2026 Medicare PFS rulemaking process.

In the meantime, CMS says that it continues to review recent data from the Census Bureau Services Annual Survey, the main data source for the 2017-based MEI weights. The data is available up to 2021, and CMS is evaluating if the trends reflect sustained shifts in cost structures or temporary impacts from the COVID-19 public health emergency. The 2022 data will be available later this year, and CMS will monitor it and other data related to physician services' input expenses. CMS says that any changes to the MEI will be proposed in future rulemaking.

Request for Comment About Evaluating E/M Services & Non-E/M Services

CMS is seeking comments on the future evolution of E/M services and other HCPCS codes. Specifically, feedback is requested on whether existing E/M HCPCS codes accurately represent the full range of E/M services and if the methods used by the RUC and CMS are suitable for accurately valuing E/M and non-E/M codes.

CMS also wants to know the potential consequences if the services described by HCPCS codes are not accurately defined or valued. Suggestions for improving processes, methodologies, and data collection for more accurate payments are welcome, as well as recommendations for timely adjustments reflecting changes in the Medicare population, treatment guidelines, and new technologies. Lastly, CMS request feedback on whether the current AMA RUC is the best entity to provide recommendations to CMS or if another independent entity would better serve this purpose.

Telemedicine Polices

CMS included many proposed policies pertaining to telehealth in the proposed rule. First, the agency plans to implement provisions from the Consolidated Appropriations Act, 2023 including 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 expansion of the definition of telehealth practitioners to include qualified occupational therapists,

qualified physical therapists, qualified speech-language pathologists, and qualified audiologists; the continued the continued payment for telehealth services furnished by RHCs and FQHCs using the methodology established for those telehealth services during the public health emergency; delaying the requirement for an in-person visit with the physician or practitioner within six months prior to initiating mental health telehealth services, and again at subsequent intervals as the Secretary determines appropriate, as well as similar requirements for RHCs and FQHCs; and the continued coverage and payment of telehealth services included on the Medicare Telehealth Services List (as of March 15, 2020) until December 31, 2024.

Additionally, CMS is proposing that, starting in 2024, telehealth services provided to beneficiaries in their homes be compensated at the non-facility rate, aligning with the telehealth-related flexibilities extended through the Consolidated Appropriations Act, 2023.

CMS is proposing to maintain the definition of direct supervision to allow the presence and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications until December 31, 2024. This extension aims to align the policy timeframe with other PHE-related telehealth policies extended under the Consolidated Appropriations Act, 2023.

CMS is inviting comments on whether it should further extend the definition of direct supervision to permit virtual presence beyond December 31, 2024. Specifically, CMS is seeking input from stakeholders regarding potential patient safety or quality concerns when direct supervision occurs virtually.

Drugs and Biologicals Which are Not Usually Self-Administered by the Patient, and Complex Drug Administration Coding

As a direct result of the AADA's and other specialty societies advocacy efforts, CMS is soliciting comments from stakeholders regarding their policies on excluding coverage for certain drugs under Part B that are usually self-administered by the patient. The agency is also seeking comments on coding and payment policies for complex non-chemotherapeutic drugs. In December 2022, the AADA along with other specialty societies, met with CMS to promote coding and payment consistency and patient access to infusion services.

Advancing Health Equity

CMS is proposing coding and payment for several new services to help underserved populations, including addressing unmet health related social needs that can potentially

interfere with the diagnosis and treatment of medical problems. This includes paying for certain caregiver training services, as well as payment for community health integration services. These are the first Medicare PFS services designed to include care involving community health workers, who link underserved communities with critical health care and social services in the community.

Additionally, the rule also proposes coding and payment for evaluating the risks related to social factors that affect a person's health that can take place during an annual wellness visit or in combination with an evaluation and management visit.

Clinical Labor Pricing

For background, in the 2022 Medicare PFS, CMS updated the clinical labor costs, which resulted in a 1% cut for dermatology practices due to budget neutrality. This update is budget neutral within the practice expense relative values, therefore (adversely) impacting specialties with procedures that utilize high-tech medical devices and/or supplies. To lessen the negative impact of payment changes, CMS implemented a gradual transition to the new rates.

For 2024, CMS is not proposing any new changes to clinical labor rates. However, the rates for 2024 slightly differ from 2023 due to CMS being in the third year of its 4-year phase-in of clinical labor price updates.

Split or Shared E/M Visits

CMS to delay, for another year, its policy on split or shared visits that was finalized in the 2022 Medicare PFS Final rule. As finalized in 2022, the billing practitioner would be the clinician that furnishes the “substantial portion” of the E/M visit. The definition of the "substantive portion" as being more than half of the total time. Instead, CMS is proposing to maintain the current definition of the substantive portion. This definition allows for either one of the three key components (history, exam, or MDM) or more than half of the total time spent to be used in determining which practitioner bills for the visit.

Skin Substitutes

CMS is requesting comments on the most effective way to establish appropriate payment for skin substitute products under the Medicare PFS. Specifically, CMS is contemplating different approaches to identify and establish direct PE inputs for skin substitutes, considering their variability and resource costs.

In February of 2023, the AADA commented on the CMS Skin Substitutes Town Hall, urging

the agency to separately identify and pay for high-cost disposable supplies. High-cost disposables distort the current practice expense RVU methodology. In cases where CPT codes include high-cost disposable supplies, a larger portion of indirect practice expenses is allocated to the practices that perform the service, which is subsidized by all other health care providers. The AADA maintains that high-cost disposables be paid separately with appropriate HCPCS codes.

Request for Information: Histopathology, Cytology, and Clinical Cytogenetics Regulations under the Clinical Laboratory Improvement Amendments (CLIA) of 1988
CMS included a Request for Information (RFI) on revisions to regulations concerning the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Specifically, CMS seeks public input on the following areas of CLIA: Histopathology; Cytology; and Clinical cytogenetics. The topics in this RFI are identified by CMS, CDC, interested parties, and surveyors for potential future rulemaking.

QUALITY PAYMENT PROGRAM POLCIY UPDATE:

<u>Changes to the Quality Payment Program (QPP)</u>
CMS proposed to increase the performance threshold in the QPP from 75 to 82 points for the 2024 Merit-Based Incentive Payment System (MIPS) performance period, impacting the 2026 payment year. As a result of the performance threshold increase, there could be more MIPS eligible clinicians receiving penalties, which could be up to -9%.

The AADA will firmly oppose any increase in the threshold and strongly urge CMS to maintain the 75-point threshold.

Performance Category Weights
The performance category weights for the 2024 performance year, affecting the 2026 payment year, will remain unchanged from the 2023 performance year. Therefore, the proposed 2024 weights are as follows:

- 30% for the Quality performance category.
- 30% for the Cost performance category.
- 15% for the Improvement Activities performance category.
- 25% for the Promoting Interoperability performance category.

MIPS Measures

The agency proposed to remove the topped-out MIPS Measure 138: Melanoma Coordination of Care. Additionally, it proposed to remove the MIPS Measure 402: Tobacco Use and Help with Quitting Among Adolescents as a quality measure from MIPS because the agency believes the measure is duplicative to measure Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.

MIPS Value Pathways (MVPs)

CMS proposed five new MIPS Value Pathways (MVPs) to be available for the 2024 performance year, and consolidated 2 previously established (Promoting Wellness MVP and Optimizing Chronic Disease Management MVP), none of which impact dermatology. The 5 newly proposed MVPs are:

1. Focusing on Women's Health
2. Quality Care for the Treatment of Ear, Nose, and Throat Disorders
3. Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV
4. Quality Care in Mental Health and Substance Use Disorders
5. Rehabilitative Support for Musculoskeletal Care.

As a reminder, CMS plans to sunset traditional MIPS and replace it with MVPs. In fact, CMS reiterated its position in the 2024 Medicare PFS that MVPs are the future of MIPS. The timeframe for making MVP reporting mandatory has not been finalized by CMS. CMS has stated that any proposal to retire traditional MIPS will be addressed in future rulemaking. AAD maintains that traditional MIPS pathway should continue to be an option.

Additional Resources

- Proposed 2024 Medicare Physician Fee Schedule
- Proposed 2024 Medicare Physician Fee Schedule Fact Sheet
- Proposed 2024 Quality Payment Program Fact Sheet