HEALTHCARE REGULATORY ROUND-UP - Episode #30

2023 Medicare Physician Fee Schedule Proposed Rule: Part I

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Introductions

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2023 Medicare Physician Fee Schedule Proposed Rule

- Released July 7
  - To be published in Federal Register on July 26
  - Supporting documentation (including appendices) available at https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1770-p
- Comments due September 7
- Final Rule published in November/December

Agenda

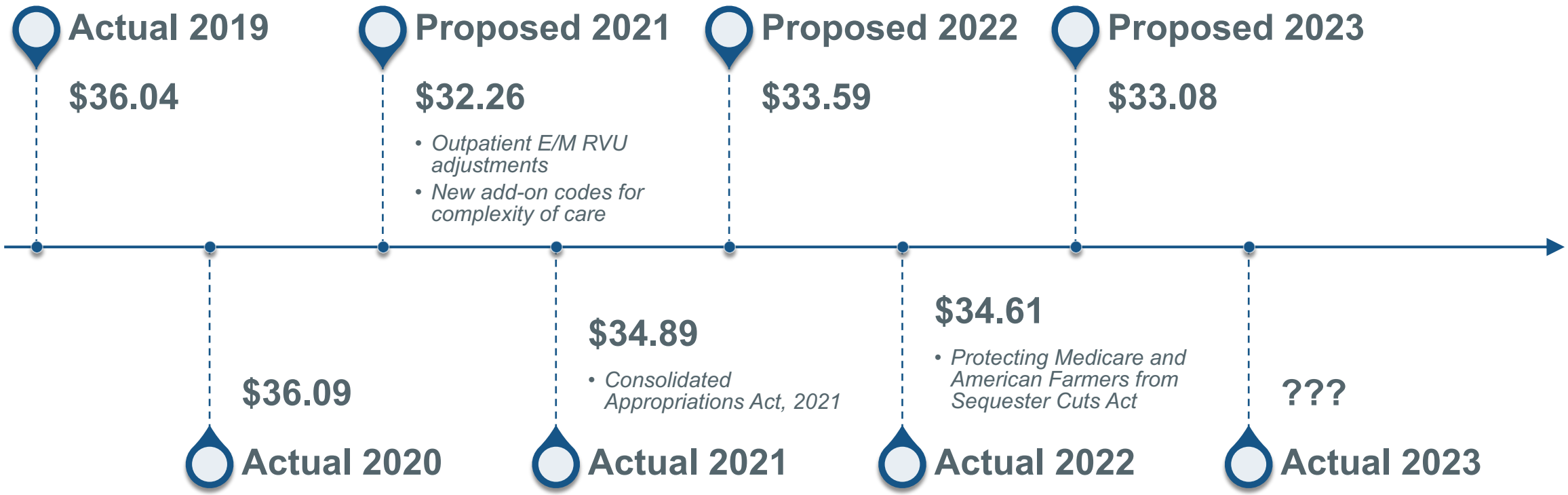
1. Conversion Factor
2. Appropriate Use Criteria
3. Telehealth
4. Virtual Services
5. RFI - Underutilized High Value Services
6. Medicare Shared Savings Program

1. Conversion Factor

Calculating Fee Schedule Payments

- **Relative value for the service**
  - Work
  - Practice expense
  - Malpractice expense
- **Conversion factor** (RVU x CF = national payment rate)
  - Dollar amount based on statutory cap on MPFS spending
  - Sustainable Growth Rate replaced in 2015 by MACRA annual adjustment factor
    - 0 adjustment factor for 2020 to 2025
  - Any increases or decreases in RVUs may not cause the amount of Medicare Part B expenditures for the year to differ by > $20 million from what expenditures would have been in the absence of these changes
  - If this threshold is exceeded, CF adjusted to preserve budget neutrality
- **Geographic adjustment factor**
  - Reflects variation in practice costs between metropolitan and non-metropolitan areas between and regions
  - Specific RVU adjustment for each MSA and non-MSA area of state
    - Average = 1 (i.e., if Region A = 1.2, then Region B = 0.8)

Conversion Factor – A Brief History (2019 – 2023)



CY2023 Proposed Conversion Factor

CY 2022 Conversion Factor		34.6062
Conversion Factor without CY 2022 Protecting Medicare and American Farmers from Sequester Cuts Act		33.5983
Statutory Update Factor	0.00 percent (1.0000)	
CY 2023 RVU Budget Neutrality Adjustment	-1.55 percent (0.9845)	
CY 2023 Conversion Factor		**33.0775**

Source of budget neutrality adjustment

- Inpatient E/M RVU adjustments
- Mis-valued code adjustments

2. Appropriate Use Criteria

Appropriate Use Criteria

- Created by Protecting Access to Medicare Act of 2014 (PAMA)
- Applies to advanced diagnostic imaging (ADI)
- Requires that the ordering professional consult a clinical decision support mechanism (CDSM) prior to ordering ADI
  - Service is appropriate, not appropriate, or not applicable

NOTICE: The payment penalty phase will not begin January 1, 2023 even if the PHE for COVID-19 ends ir 2022. Until further notice, the educational and operations testing period will continue. CMS is unable to forecast when the payment penalty phase will begin.

3. Telehealth

Medicare Telehealth Coverage Pre-COVID-19

Section 1834(m)

1. **Geographic** - Patient must reside in rural area
2. **Location** - Patient must be physically present at healthcare facility when service is provided (facility fee)
3. **Service** – Coverage limited to CMS' list of approved telehealth services (CPT and HCPCS codes)
4. **Provider** – Service must be provided by physician, non-physician practitioner, clinical psychologist, clinical social worker, registered dietician, or nutrition professional
5. **Technology** - Must utilize telecommunications technology with audio *and* video capabilities that permits real-time interactive communication.

Medicare Coverage Pre-COVID-19

With Some Exceptions

- **Telestroke**
  - Effective 01/01/2019, geographic and location requirements do not apply to services furnished to diagnose, evaluate, or treat symptoms of acute stroke
- **Substance Use Disorder**
  - Effective 07/01/2019, geographic and location requirements do not apply to services relating to SUD and co-occurring behavioral health conditions
- **ESRD**
  - Effective 01/01/2019, geographic and location requirements do not apply to ESRD services relating to home dialysis
- **Medicare Advantage**
  - Beginning in 2020 plan year, MA plan may eliminate geographic and location requirements
- **Medicare Shared Savings Program**
  - Waiver of geographic and location requirements for ACO participants in risk models
- **CMMI Initiatives**

Medicare Telehealth Coverage Expansion

1. Legislative Action

- Waived *geographic* and *location* restrictions for duration of PHE; authorized Secretary to waive other Section 1834(m) requirements for duration of PHE

2. CMS Interim Final Rules

- Suspends certain *service* restrictions for duration of PHE
  - Expands list of covered services
  - Eliminates frequency requirements
  - Permits use of telehealth for required face-to-face visits, direct supervision for incident-to billing, teaching physician presence
- Suspends certain *provider* restrictions for duration of COVID-19 PHE
  - Waives Medicare state licensure requirement (but not state law requirements)
  - Permits therapists and S/L pathologists to provide covered services via telehealth
  - Permits FQHCs and RHCs to bill for telehealth services under HCPCS G2025
  - Permits billing for hospital outpatient department and CAH services furnished via telehealth
- Authorizes payment for certain audio-only E/M services (CPT 98966-68, 99441-43)
- Provides reimbursement for telehealth services at higher non-facility rates to compensate practices for telehealth-associated costs

Tele-Behavioral Health

- Consolidated Appropriations Act, 2021 – eliminate geographic and location restrictions for diagnosis, evaluation, and treatment of mental health disorder
- Must have in-person, non-telehealth service by practitioner in same practice as billing practitioner within 6 months prior to initial telehealth service + each 12 months thereafter
  - Exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with reason documented in beneficiary's medical record)
- May use audio-only communication technology (vs. audio/video required for other telehealth services) but only if -
  - Practitioner has audio/video capability + beneficiary lacks capacity or refuses to use video connection
    - Documented in medical record + include service-level modifier on claim

Telehealth Flexibility Extensions

Enacted March 15, 2022

- Extend for 151 days post-PHE certain PHE-related telehealth policies for services included on Medicare Telehealth Services List as of date of enactment –
  - ✓ Continuation of waiver of geographic and location requirements
  - ✓ Continuation of reimbursement for therapist and S/L pathologist telehealth services
  - ✓ Continuation of reimbursement for audio-only services
  - ✓ Continuation of FQHCs and RHCs for telehealth services
  - ✓ Continuation of use of telehealth to recertify eligibility for hospice case
  - ✓ Delay in in-person requirement for initiation of tele-behavioral health services

Medicare Telehealth Services List

- Extend coverage for all services included on temporary basis for 151 days post-PHE (including those added after 3/15/22)
  - https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- Identify those services included on temporary basis for which coverage will not be continued through 12/31/23 (Table 10)
  - Telephone E/M visit codes (CPT 99441-43)
  - Initial care (observation, hospital, nursing facility, domiciliary/rest home, home)
- Add new Category I codes
  - GXXX1-3 (prolonged inpatient, nursing facility, home/residence services by physician/NPP)

HCPCS	Short Descriptor
77427	Radiation tx management x5
92002	Eye exam new patient
92004	Eye exam new patient
92550	Tympanometry & reflex thresh
92552	Pure tone audiometry air
92553	Audiometry air & bone
92555	Speech threshold audiometry
92556	Speech audiometry complete
92557	Comprehensive hearing test
92563	Tone decay hearing test
92565	Stenger test pure tone
92567	Tympanometry
92568	Acoustic refl threshold tst
92570	Acoustic immitance testing
92587	Evoked auditory test limited
92588	Evoked auditory tst complete
92601	Cochlear implt f/up exam <7
92625	Tinnitus assessment
92626	Eval aud funcj 1st hour
92627	Eval aud funcj ea addl 15
93750	Interrogation vad in person
94002	Vent mgmt inpat init day
94003	Vent mgmt inpat subq day
94004	Vent mgmt nf per day
96125	Cognitive test by hc pro
99218	Initial observation care
99219	Initial observation care
99220	Initial observation care
99221	Initial hospital care
99222	Initial hospital care
99223	Initial hospital care
99234	Observ/hosp same date
99235	Observ/hosp same date
99236	Observ/hosp same date
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99324	Domicil/r-home visit new pat
99325	Domicil/r-home visit new pat
99326	Domicil/r-home visit new pat
99327	Domicil/r-home visit new pat
99328	Domicil/r-home visit new pat
99341	Home visit new patient
99342	Home visit new patient
99343	Home visit new patient
99344	Home visit new patient
99345	Home visit new patient
99441	Phone e/m phys/qhp 5-10 min
99442	Phone e/m phys/qhp 11-20 min
99443	Phone e/m phys/qhp 21-30 min
99468	Neonate crit care initial
99471	Ped critical care initial
99475	Ped crit care age 2-5 init
99477	Init day hosp neonate care

Post-PHE Telehealth – Claims Submission and Payment

- Through Day 151 -
  - Will continue to pay non-facility rate for claims with modifier 95
  - Report POS code that would have been reported if service furnished face-to-face
- Day 152 and thereafter –
  - Discontinue modifier 95; use POS 02 (telehealth provided other than patient's home) or POS 10 (telehealth provided in patient's home)
  - Payment at lower facility rate ("We believe that the facility payment amount best reflects the practice expense, both direct and indirect, involved in furnishing services via telehealth")
  - Include modifier 93 for audio-only services (including RHCs, FQHCs, and OTPs)
- CMS will issue sub-regulatory guidance as needed to implement Telehealth Flexibilities Extension following end of PHE

Direct Supervision

- Current status
  - Pre-PHE: Supervising physician/NPP physically present and immediately available to provide assistance
  - During PHE: Virtual presence using real-time audio/video technology
  - Post-PHE: Continue virtual presence through December 31 of year in which PHE ends; thereafter, revert to physical presence requirement
- CMS does not propose further extension of virtual supervision – “we continue to seek information on whether [virtual supervision] should potentially be made permanent” for some or all services

4. Virtual Services

Virtual Services

- No proposals relating to transitional care management, chronic care management, or remote physiologic monitoring
  - Reduction in RPM reimbursement (e.g., 12% cut in monthly monitoring (CPT 99454))
- New codes for remote therapeutic monitoring treatment management services
- New reimbursement for remote therapeutic monitoring for cognitive behavioral therapy
- New reimbursement for chronic pain management

Remote Therapeutic Monitoring

- Replace current treatment management codes (CPT 98980 and 98981)
  - GRTM1 and GRTM2
    - Furnished by clinical staff under general supervision of billing practitioner
  - GRTM3 and GRTM4
    - Furnished by PTs, OTs, or SLPs under therapy plan of care
- Clarification of billing rules
  - Must bill CPT 98975 and 98976/98977 (initial patient education and monthly monitoring) prior to reporting GRTM1-4
  - Cannot bill GRTM1/2 and GRTM3/4 in same month; cannot bill RPM or cardiac device evaluations in same month as RPM

Cognitive Behavioral Therapy Monitoring

- Presently, RTM limited to respiratory system (CPT 98976) and musculoskeletal system (CPT 98977)
- CMS proposes to include CPT 989X6, monitoring for cognitive behavioral therapy
  - Because technology still evolving, will remain contractor priced

"We appreciate the continuing dialogue about the remote monitoring codes and welcome comments including any additional information that …. may provide further clarity on how remote patient monitoring services are used in clinical practice, and how they would be most appropriately coded, billed and valued under the Medicare PFS."

Chronic Pain Management

- Monthly bundle of chronic pain management and treatment services
  - Bundle includes diagnosis; assessment and monitoring; administration of pain rating scale; care plan development and maintenance; overall treatment management; coordination of behavioral health treatment; medical management; health literacy; crisis care; care coordination with other providers
- Prerequisites
  - Chronic pain diagnosis
  - Initial face-to-face visit (min. 30 minutes)
  - Verbal consent
- Reimbursement
  - GYYY1 ($78.73) – first 30 minutes/month personally performed by billing practitioner
  - GYYY2 ($28.12) – each additional 15 minutes/month

CPM Request for Comment

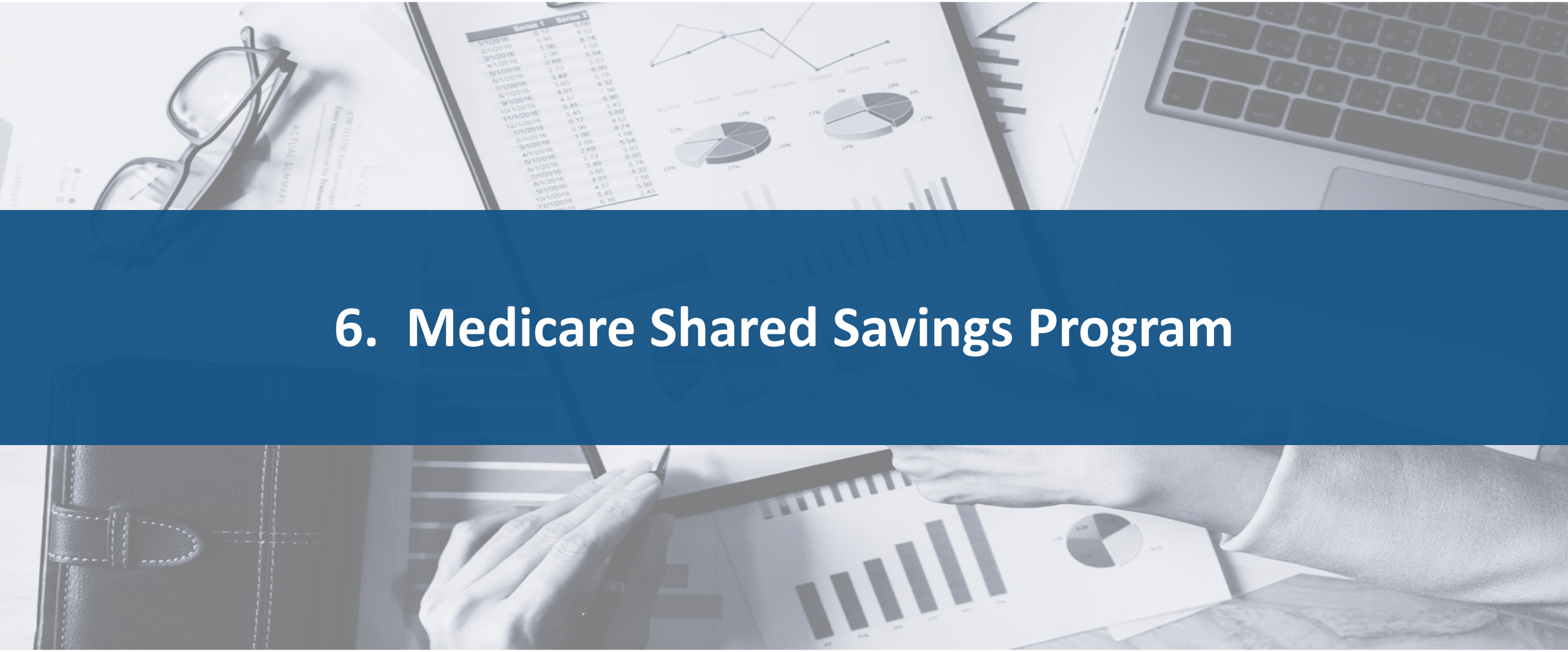
- May be billed by up to 2 practitioners per month (e.g., PCP and pain specialist)
- May be billed with other care management services (CCM, RPM, BHI)
- Certain components performed by clinical staff incident to billing practitioner’s services?
- Duration and frequency limitations for GYYY2?
- Permit initial visit to be performed via telehealth?

5. RFI – Potentially Underutilized Services

We are seeking comments on ways to identify specific services and to recognize possible barriers to improved access to these kinds of high value, potentially underutilized services by Medicare beneficiaries. We are also seeking comment regarding how we might best mitigate some of these obstacles, including for example, through examining conditions of payment or payment rates for these services or by prioritizing beneficiary and provider education investments.

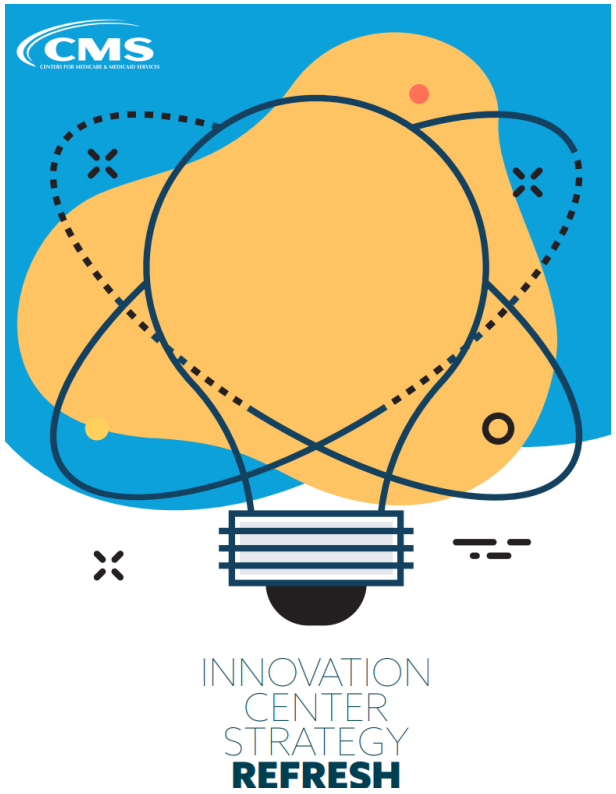
A Few Thoughts …

- Re-evaluation of practice expense RVUs (start-up costs, technology)
- Elimination of established patient, verbal consent requirements for virtual services
- Exercise of enforcement discretion under prohibition on beneficiary inducements for waivers of co-insurance
- Publication of definitive guidance on billing requirements (one stop shop)
- MIPS quality measure and performance improvement activities



6. Medicare Shared Savings Program

CMS Accountable Care Strategy



- By 2030, all traditional Medicare beneficiaries and most Medicaid beneficiaries will be in care relationships with accountability for quality and total cost of care
  - Advanced primary care models
  - Specialty episodic payment models
  - Accountable care organizations
- Tactics
  - Engage providers
  - Improve benchmarking and performance measures
  - Enable provider participation in downside risk

https://innovation.cms.gov/strategic-direction-whitepaper

MSSP Proposed Changes

1. Delay mandatory transition to two-sided risk
2. Improve benchmarks
3. Add health equity adjustment
4. Provide advanced shared savings payments
5. Update quality scoring metrics
6. Reduce administrative burden

1. Transition to Two-Sided Risk

- Since 2019, ACOs required to transition to two-sided risk within 2 years
  - CMS waived requirement for PY 2021 and PY 2022
    - For PY 2021, 89% of eligible ACOs remained in one-sided risk; 74% did the same in PY 2022
- For PY 2023, ACOs presently in one-sided risk can elect to remain at current level for remainder of agreement
- Beginning in PY 2024, ACOs inexperienced with downside risk may remain in one-sided risk for up to 7 years (initial 5-year agreement + first 2 years of second 5-year agreement)

2. Benchmark Methodology

- Include Accountable Care Prospective Trend (in addition to national and regional growth rates) to account for impact of MSSP participation on relevant market
- Incorporate prior savings adjustment in historical benchmarks for renewing and re-entering ACOs to mitigate rebasing ratchet effect
- Reduce impact of negative regional adjustment and revise calculation of regional factors
- Revise application of 3% cap on positive prospective HCC risk score growth to better account for high-cost populations
- No changes to address reduction in utilization in 2020, at least for now
- Request for comment on administratively-set benchmarks (vs. use of historical data)

3. Health Equity Adjustment

- Upward adjustment to MIPS quality performance category score for those ACOs serving underserved populations (based on Area Deprivation Index and proportion of dual eligible beneficiaries)
  - Potential to increase ACO's sharing rate

4. Advance Investment Payments

- Option for new (not renewing or re-entering) ACOs whose participants' total Medicare revenue is less than 35% of total Medicare expenditures for ACOs' assigned beneficiaries (low volume ACOs)
- Receive one-time payment of $250,000 + 8 quarterly payments based on characteristics of attributed beneficiaries
- Restricted use of funds
  - Improve provider infrastructure
  - Increase staffing
  - Provide accountable care for underserved beneficiaries (e.g., addressing social needs)
- Payments recouped from future savings; no repayment obligation if no savings (unless terminate participation)
- Separate proposal regarding application of minimum savings rate for same ACOs

5. Quality Measures

- Re-institute use of sliding scale approach to determine shared savings based on quality score (vs. all-or-nothing approach)
- Extend through PY 2024 incentive for reporting eCQMs/MIPS CQMs (to align with the sunsetting of the CMS Web Interface reporting option)
- Adopt benchmarking policies to establish quality measure benchmarks and minimum attainment level for CMS Web Interface measures for PYs 2022, 2023 and 2024

6. Administrative Burden

- Reduce frequency with which beneficiary information notices must be provided (once per agreement period with follow-up communication within 180 days of providing notice)
- Eliminate requirement to submit marketing materials to CMS for review and approval prior to dissemination
- Modifications to streamline the SNF 3-day rule waiver application review process
- Update data sharing regulations to permit ACOs acting as organized health care agreements (OHCAs) to request aggregate reports and beneficiary-identifiable claims data from CMS
- Permit ACOs to structure themselves as OHCAs to reduce burden with reporting eCQMs/MIPS CQMs

Our Next Regulatory Round-Ups

2023 Medicare Physician Fee Schedule Proposed Rule, Part II – August 3

E/M, Split/Shared Visits, MEI, Behavioral Health, Global Surgical Package, Dental Coverage

2023 Medicare Physician Fee Schedule Proposed Rule, Part III - August 10

Quality Payment Program Update

2023 Hospital OPPS/ASC Proposed Rule – August 17

2023 Hospital IPPS, Inpatient Rehab, Inpatient Psych, and SNF Final Rules – Dates TBD

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