Medicare 2024 Proposed Physician Payment Policies Released

On July 13, 2023, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2024 Medicare Physician Fee Schedule (PFS) proposed rule. The rule will be posted in the Federal Register no later than August 7, 2023.

CMS has proposed a CY 2024 Physician Conversion Factor (CF) of $32.7476, which represents an approximately 3.36% reduction from the CY 2023 Physician CF of $33.8872. The CF amount reflects a statutorily required update of 0% scheduled for CY 2024, a negative 2.17% budget neutrality adjustment, and a funding patch passed by Congress at the end of CY 2022 through the Consolidated Appropriations Act of 2023 (CAA, 2023), which partially mitigated a cut to the CY 2023 CF as well as a portion of the expected cut in the CY 2024 CF.

Evaluations and Management (E/M)

CMS is proposing to implement a separate add-on payment for healthcare common procedure coding system (HCPCS) code G2211 (Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care 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). While this new add-on service contributes to the cuts in CF, our members will be able to report this new code. Payment for the physician work of the G2211 add-on code is proposed at $10.81.

CMS believes this add-on code will better recognize the resource costs associated with E/M for primary care and longitudinal care of complex patients. Generally, it will be applicable for outpatient office visits as an additional payment, recognizing the inherent costs clinicians may incur when longitudinally treating a patient’s single, serious, or complex chronic condition. It should not be billed with a modifier that denotes an office and outpatient E/M visit that is itself unbundled from another service (e.g., a procedure where complexity is already recognized in the valuation).

Telemedicine

CMS plans to implement several telehealth-related provisions of the CAA, 2023, including:

- Continued coverage and payment of telehealth services included on the Medicare Telehealth Services List (as of March 15, 2020) until December 31, 2024.
- Audio-only (telephone) CPT codes 99441 - 99443 are telehealth services and will remain actively priced through 2024.
- Payment of telehealth services furnished to people in their homes at the non-facility PFS rate to protect access to mental health and other telehealth services by aligning with telehealth-related flexibilities that were extended via the CAA, 2023.
• Continuing to define direct supervision to permit the presence and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications through December 31, 2024.
• 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 continued payment for telehealth services furnished by rural health clinics (RHCs) and Federally Qualified Health Centers (FQHCs) using the methodology established for those telehealth services during the public health emergency.

Split/Shared Visits

CMS proposes to delay the implementation of the definition of the “substantive portion” as more than half of the total time with the patient, through at least December 31, 2024. Instead, CMS will maintain the current definition of substantive portion for CY 2024 that allows for use of either one of the three key components (history, exam, or medical decision making) or more than half of the total time spent to determine who will bill for the visit.

Updating the Medicare Economic Index (MEI) for CY 2024

In its CY 2023 PFS rulemaking, CMS finalized its proposal to rebase and revise the MEI to reflect more current market conditions faced by physicians in providing services. CMS will use a 2017-based MEI that relies on a methodology that uses publicly available data sources for input costs that represent all types of physician practice ownership, not limited to only self-employed physicians. In light of the AMA’s intended data collection efforts on physician practice expenses and because the methodological and data sources changes to the MEI will have significant impact on PFS payments, CMS proposes to delay implementation of the finalized 2017-based MEI cost weights and not incorporate the new cost weights for CY 2024.

Provisions from the Inflation Reduction Act Relating to Drugs and Biologicals Payable Under Medicare Part B

The Inflation Reduction Act of 2022 contains several provisions that affect payment limits or beneficiary out-of-pocket costs for certain drugs payable under Part B. In this proposed rule CMS addressed the following:

• Amending the payment limit for new biosimilars furnished on or after July 1, 2024, during the initial period when average sales price (ASP) data is not available. The payment for the biosimilar will be the lesser of (1) an amount not to exceed 103% of the wholesale acquisition cost (WAC) of the biosimilar or the Medicare Part B drug payment methodology in effect on November 1, 2003, or (2) 106% of the lesser of the WAC or ASP of the reference biologic, or in the case of a selected drug during a price applicability period, 106% of the maximum fair price of the reference biological.
• Increasing the payment for certain biosimilars, to ASP plus 8 percent of the reference biologic’s ASP, rather than 6 percent during a 5-year period.
• Conforming changes to regulatory text to reflect the following provisions: Section 11403 makes changes to the payment limit for certain biosimilars with an ASP that is not more than the ASP of the reference biological for a period of five years.
• Conforming the following changes to regulatory text: Section 11101 requires that beneficiary coinsurance for a Part B rebateable drug is to be based on the inflation-adjusted payment amount if the Medicare payment amount for a calendar quarter exceeds the inflation-adjusted payment amount, beginning on April 1, 2023.

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

CMS is soliciting comments regarding policies on the exclusion of coverage for certain drugs under Part B that are usually self-administered by the patient. The Agency is also seeking comment on coding and payment policies for complex non-chemotherapeutic drugs, in an effort to promote coding and payment consistency and patient access to infusion services.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Program

CMS is proposing to pause efforts to implement the AUC program for reevaluation and to rescind the current AUC program regulations, which effectively discontinues the program’s educational and operations testing period. CMS will continue efforts to identify a workable implementation approach and will propose to adopt any such approach through subsequent rulemaking.

Health Equity

CMS is proposing coding and payment for several new services to help underserved populations. We applaud the Administration’s commitment to advance health equity and expand access to critical medical services. This ongoing effort to implement and operationalize these policies will support people who are disadvantaged or underserved and provide the care and support those patients require.

Quality Payment Program (QPP)

CMS also proposes to make adjustments to the Merit-based Incentive Payment System (MIPS), including:

• Increasing the quality measure data completeness threshold from 70% to 75% for three years (performance years 2024-2026) and to 80% for 2027-2029.
• Requiring for the 2024 performance year a continuous 180-day performance period for the Promoting Interoperability performance category. Currently, the performance period is a continuous 90-day period.
• Increasing the performance threshold for the 2024 performance year to avoid a penalty from 75 points to 82 points. Providers unsuccessfully participating in the QPP will receive a payment cut of 9% in 2026.

Also, CMS proposes to remove Measure 113 “Colorectal Cancer Screening Percentage of patients 45-75 years of age who had appropriate screening for colorectal cancer” from the traditional MIPS Quality performance category. CMS proposes to include this measure (and other screening measures) in a “Preventive Care and Wellness” composite measure.
CMS is proposing 5 new Merit-based Incentive Payment System Value Pathways (MVPs) for CY 2024, including, “Focusing on Women’s Health,” “Quality Care for the Treatment of Ear, Nose, and Throat Disorders,” “Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV,” “Quality Care in Mental Health and Substance Use Disorders,” and “Rehabilitative Support for Musculoskeletal Care.”

**CY 2024 Medicare Proposed Physician Payment Charts**

- [2024 Proposed Medicare Physician Payments](#)
- [2024 Proposed Medicare Relative Value Unit Changes](#)

**CMS Proposed Rule and Fact Sheets**

- [2024 Medicare Physician Fee Schedule Proposed Rule](#)
- [2024 Medicare Physician Fee Schedule Proposed Rule Fact Sheet](#)
- [2024 Quality Payment Program Fact Sheet](#)