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# November 2023

## CMS Finalizes 2024 Physician Payment Rule

- On November 2, CMS issued the Medicare Physician Fee Schedule final rule for Calendar Year 2024. The payment rule sets payment rates for physician offices, hospitals, ASCs, laboratories, and other care settings. The rule also makes adjustments to Medicare value-based care programs, i.e., the Quality Payment Program and the Merit-Based Incentive Payment System (MIPS). Next year, federal law requires a 1.25% payment cut in addition to a new conversion factor that is 3.4% lower than 2023. CMS is also putting more emphasis on primary care by introducing an add-on payment code for evaluation and management (E&M) for ongoing general health services and complex conditions. CMS estimates that the redistribution for other payments caused by adding this code will be lower than originally expected. In the rule, CMS is also bolstering behavioral healthcare by adjusting the reimbursement methodology for in-person psychotherapy services provided in a clinic setting. Other substantial policy changes include payments for caregiver training, coding for social determinants of health assessments, expanded telehealth coverage, and implementation of Part B drug payment changes related to Medicare negotiation and drug waste refunds.

## CMS Finalizes Other Healthcare Rules

- In late October and early November, CMS released multiple healthcare regulations as part of its annual rulemaking cycle:
  - The Medicare Advantage (MA) and Prescription Drug Coverage proposed rule would limit insurance agent and broker fees paid by MA plans to prevent patient steering, increase network adequacy standards for behavioral healthcare providers, change the requirements for MA plan supplemental benefits, and require health equity analyses of plans' utilization management policies.
  - The 2024 Home Health Prospective Payment System (HH PPS) final rule sets payment rates for home health agency Medicare payments. CMS is finalizing a home health 30-day payment rate adjustment based on data from the implementation of the Patient Driven Groupings Model (PDGM) and other adjustments that correspond with a 0.8% total increase in home health payments.

- The 2024 Hospital Outpatient Prospective Payment System final rule determines hospital and Ambulatory Surgical Center (ASC) payments and requirements for quality reporting programs. The final conversion factor will increase payments by 3.1%, with higher increases for rural hospitals. The rule will also establish a new program for intensive outpatient services, set standards for hospital price transparency data, and solicit comments on stockpiling essential medicines.
- The related Hospital Outpatient Prospective Payment System (OPPS) Remedy for 340B-Acquired Drug Payment final rule will provide a lump sum of $9 billion dollars to safety net hospitals after a 2018 to 2022 regulatory decision on drug reimbursement was reversed by the Supreme Court earlier this year. But because of budget neutrality rules, CMS has increased hospital payments in other areas. As a result, CMS must offset $7.8 billion in other non-drug payments to hospitals by lowering the OPPS payment rate by 0.5% in future years. The growth of 340B payments to hospitals through contracts with retail pharmacies has increased greatly in recent years and has been contentious issue for stakeholders on both sides.
- The 2024 End-Stage Renal Disease (ESRD) Prospective Payment System final rule will increase renal dialysis base payment rate by 2.1%, create a transitional payment adjustment for innovative dialysis drugs and products, establish a supplementary pediatric dialysis payment, and solicit feedback on payment for geographically isolated dialysis facilities.

## House of Representatives Considers Multiple Physician Payment Bills

- On October 19, the House Energy and Commerce Subcommittee hosted a hearing on healthcare legislation related to supporting Medicare physician payment rates and minimizing regulatory burdens on clinicians. Multiple bills have been drafted to reduce the burden of reimbursement cuts set to take effect on January 1, 2024, and address other provider-focused issues. Proposals include increasing the value of office-based practice expenses, providing yearly inflation-based offsets using the Medicare economic index, simplifying requirements for MIPS, and increasing payments for laboratory testing. At the end of each calendar year, provider groups like the American Medical Association urge Congress to prevent cuts related to budget neutrality and other factors. In 2023, when providers faced large payment cuts of 8.5%, Congress used an end-of-year spending bill to delay the budget neutral Pay-As-You-Go (PAYGO) cuts and phased in another payment reduction for physicians over 2 years, resulting in a 2% combined reduction.

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## Government Agencies Propose Information Blocking Penalties

- On November 1, HHS, the Office of the National Coordinator (ONC), and CMS released a proposed rule that penalizes Medicare vendors and providers from information blocking – preventing the sharing of Electronic Health Records (EHR) or other federally-certified healthcare Information Technology (IT). This rule is part of an ongoing process to implement provisions in the 21st Century Cures Act that promotes interoperability across healthcare IT systems. The rule establishes civil monetary penalties of up to $1 million per violation and specifically applies to clinicians, physician groups like ACOs, and hospitals that participate in Medicare EHR Incentive Programs, the Medicare Shared Savings Program, or the Merit-Based Incentive Payment System. The law was passed because of concerns that EHR vendors were preventing information sharing through contract terms or fees that limit patients' and physicians' use of medical data and connection with other IT systems. However, industry groups are concerned that stakeholder's understanding of the law and ability to comply with technical requirements may pose issues with compliance.

## States Pass New Drug Pricing and PBM Laws in 2023

- In 2023, many state legislatures passed drug pricing laws that will take effect in 2024. Minnesota became the 7th state to create a drug affordability review board that assesses the impact of high-cost drugs and can set an upper payment limit for payment by public payers. The Michigan state legislature is still considering a similar bill and is in session until the end of the year. The other states with review boards (Colorado, Maryland, and Oregon) expanded their powers and scope through legislation this year. Other states considered using the "Maximum Fair Price" set by Medicare price negotiation as an upper payment limit, but none of these bills ultimately passed. Over a dozen states passed bills limiting PBMs from using spread pricing in pharmacy contracts by requiring a 100% pass through of any rebates or discounts to health plans.

## Other Policy News:

- Healthcare.gov enrollment for Marketplace coverage began on November 1
- CMS beginning Medicare price negotiations with 10 drug manufacturers
- CMS provides an update on upcoming drug pricing initiatives: the Medicare $2 Drug List Model for Part D generic drugs, the Accelerating Clinical Evidence Model, and the Cell and Gene Therapy Access Model
- CBO calls for more research on the effects of obesity treatments on healthcare spending and federal Medicare budgets

- State Attorneys General file lawsuit against Fresenius for unnecessary diabetes procedures
- Medicaid unwinding continues across the US as more than 10 million have been disenrolled