

July 2024

CMS Releases Proposed Physician Payment Rule

- On July 10, CMS [released](#) the 2024 Medicare Physician Fee Schedule (MPFS) proposed rule which sets reimbursements and implements other policy changes for Medicare providers and specialists. In this rule, CMS proposes a statutory reduction of 2.93% compared to 2024 when factoring in the expiration of an increase from last year and changes to the Relative Value Units (RVUs) of certain services. One significant change includes the creation of an advanced primary care services bundle based on patient complexity and tied to quality measures as part of a long-term effort. CMS is also proposing new payment and coding for cardiovascular risk assessments and care management based on promising results of a recent [demonstration](#) program. Other proposed changes include the new Merit-based Incentive Payment System (MIPS) Value Pathways for certain specialties and new methodologies, and soliciting feedback on a new value-based care model for specialists. There are also a number of proposed structural changes to the Medicare Shared Savings Program that encourage investment in support services, health equity, and the use of universal quality measures.
- CMS is also focusing on other priorities that include behavioral health, oral health, and caregiver training. CMS proposes a new payment for assisting patients at risk of suicide or overdose, digital health tools for behavioral health, and opioid treatment programs. CMS is also now proposing payment for certain dental services related to dialysis and

End-Stage Renal Disease (ESRD) treatment, and payment for caregiver training services. Other statutory changes relate to the expiration of telehealth flexibilities in 2025 and implementation of inflationary drug rebates that will go towards funding the Medicare Trust Fund and support long-term sustainability of Medicare. As in previous years, Congress may offset these payment decreases through legislation in response to advocacy by physician groups for adequate payment.

MedPAC Releases Report on Physician Payment Recommendations

- On June 13, the Medicare Payment and Access Commission (MedPAC) released a [report](#) that addressed Medicare's payment to clinicians and incentives to participate in Alternative Payment Models (APMs). MedPAC periodically recommends Medicare policy changes to Congress, but their suggestions are non-binding. MedPAC has offered similar recommendations in the past that acknowledge that provider payments have not kept up with inflation and could begin to affect patient access without a permanent fix by Congress. The Commission has expressed concerns that payments to physicians and specialists are not adequate even though patient access has been similar to private coverage historically. Today, Medicare physician payment is set to increase by 0.75% to those participating in qualifying APMs, and 0.25% for all other clinicians in 2025; however, medical inflation costs are projected to rise by an average of 2.3% over the next 5 years. Other issues with payment adequacy relate to incentives for procedures to be performed in a Hospital Outpatient Department (HOPD) versus a free-standing physician office, which has led to vertical consolidation of physician groups by health systems. MedPAC suggests either increasing reimbursement for the practice expense

calculation of CPT codes, using the Medicare Economic Index for payment increases, or implementing site-neutral payments. MedPAC also recommends extending bonuses for participation in APMs to ensure that there are larger incentives for the Merit-based Incentive Payment System (MIPS) for top-performing providers. This report highlights the disparity between Medicare physician payment in the context of the proposed fee schedule for 2025 and ongoing calls for a payment system similar to hospitals and home health for healthcare providers that rely on CMS reimbursement.

Appeals Court Gives Limited Ruling on Preventive Coverage

- On June 21, a court handed down a [decision](#) in much anticipated ruling on the ACA's preventive coverage mandate which includes HIV prophylaxis coverage, referred to as PrEP. The ruling only applies to the 8 employers involved in the suit who raised religious objections and is not applicable nationwide. Currently, all recommended preventive services are required to be offered at no cost to patients. The suit will now go back to a lower court for further clarification of other issues raised, as the opinion does not address whether coverage recommendations by 2 separate advisory committees on vaccines and women and children's health care are also unconstitutional. The ruling further states that insurers providing coverage to those businesses could choose to adopt copays or deductibles to maintain access. Previously, a district court ruled that the requirements were a violation of the Constitution because the United States Preventive Services Task Force in charge of assessing preventive services is not nominated by the Executive nor confirmed by the Senate. While the ruling [creates](#) opportunities for new legal challenges, insurers must still offer preventive services with no cost sharing and still have certain financial incentives to promote prevention over treatment in HIV care and other areas.

Other Policy News:

- CMS proposes annual payment rules with increases to [hospital payment](#) and decreases for [home health payment](#)
- CMS [announces](#) voluntary model for supporting patients with dementia and their caregivers
- Senators send letter to CMS [requesting](#) increased oversight of AI in Medicare Advantage coverage decisions
- Survey [finds](#) that surgeons prefer in-person visits over telehealth to assess risk and avoid malpractice and reimbursement issues
- DOJ [announces](#) large scale action in healthcare fraud cases related to telemedicine and improper prescribing
- Research [suggests](#) that drug price negotiation may increase out-of-pocket costs for Medicare beneficiaries taking selected drugs due to higher copays
- House committee [votes](#) in favor of Medicare covering obesity drugs for those taking the drugs before they turn 65 to maintain continuity of coverage
- Members of Congress call for [investigation](#) into improper ACA enrollment tied to enhanced premium subsidies