2023 MID-YEAR WASHINGTON UPDATE

SEPTEMBER 2023

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JAMES HAYNES, JD

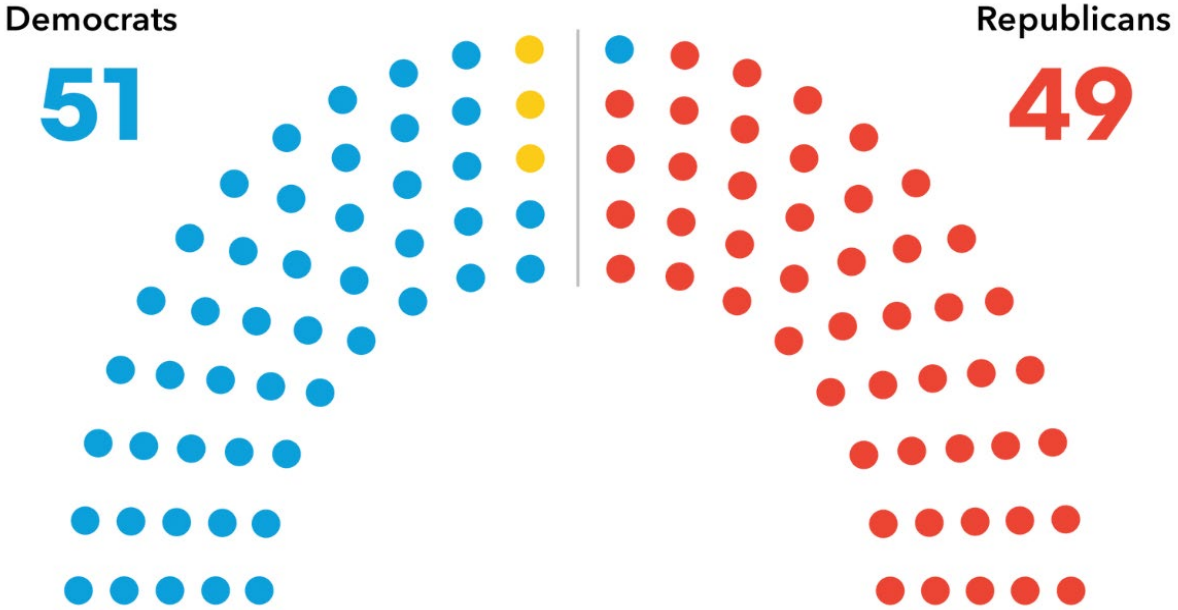
MGMA GOVERNMENT AFFAIRS

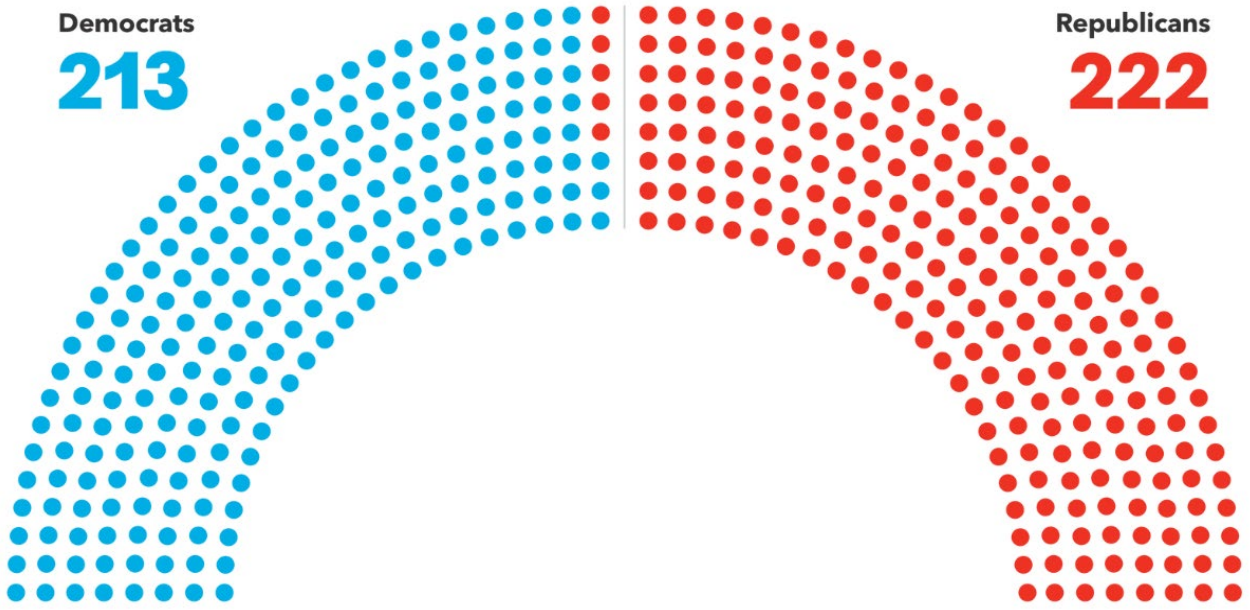
HOW DO WE ADVOCATE FOR YOU IN D.C.?

- Solicit feedback from MGMA members regarding challenges stemming from federal policies
- Inform policy makers of these challenges & work towards solutions
- Educate MGMA members on policy changes that affect their practices

POLITICAL ENVIRONMENT IN D.C.

NARROW MARGINS MAKE FOR POTENTIAL STALEMATES





SOURCE: BLOOMBERG GOVERNMENT https://about.bgov.com/brief/balance-of-power-republican-majority-in-the-house/ https://about.bgov.com/brief/balance-of-power-a-partisan-convergence-in-the-senate/

CONGRESSIONAL HEALTHCARE PRIORITIES

118TH CONGRESS

- Healthcare workforce issues
- Cybersecurity within healthcare settings and with healthcare devices
- Medicare Advantage reform
- Consolidation and competition
- Drug prices

ISSUES TO WATCH

- Potential cuts to Medicare reimbursement in 2024
- Prior authorization reform on the horizon in Medicare Advantage
- Telehealth policies continue to evolve but permanent reform unlikely this year
- Site of service differentials under the spotlight
- Health information technology regulations expected — information blocking & HIPAA

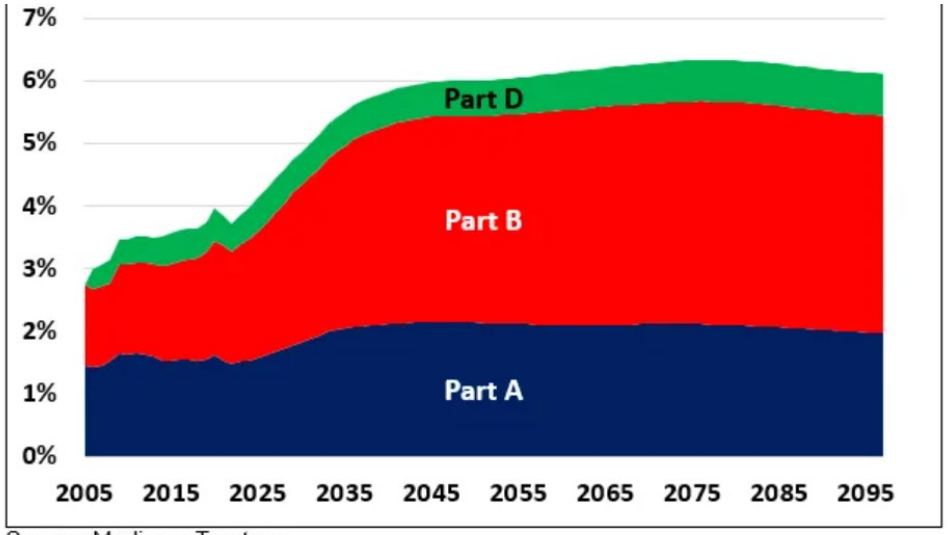
VIEW MGMA'S 2023 ADVOCACY AGENDA

THE LARGER FEDERAL POLICY PICTURE

ENTITLEMENT REFORM

- Medicare solvency issues
- Why does this matter? Difficult to ask for positive payment updates

TOTAL MEDICARE SPENDING BY PART (% OF GDP)



Source: Medicare Trustees.

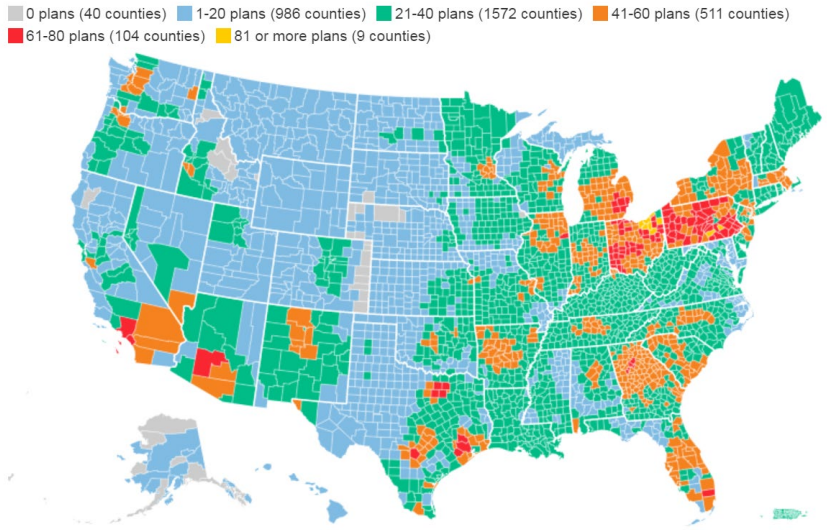
SOURCE: https://www.crfb.org/papers/analysis-2023-medicare-trustees-report

THE LARGER FEDERAL POLICY PICTURE

MEDICARE ADVANTAGE (MA)

- Highly politicized by both parties, but both branches are cracking down on MA
- Overpayments and high utilization, marketing, prior authorization reform
- Why does this matter? MA is growing — the Congressional Budget Office (CBO) **projects** that the share of all Medicare beneficiaries enrolled in MA will rise to 61% by 2032

OF MA PLANS AVALABLE



NOTE: Excludes SNPs, EGHPs, HCPPs, PACE plans, cost plans, and MMPs.
SOURCE: KFF analysis of CMS Landscape files for 2023. • PNG

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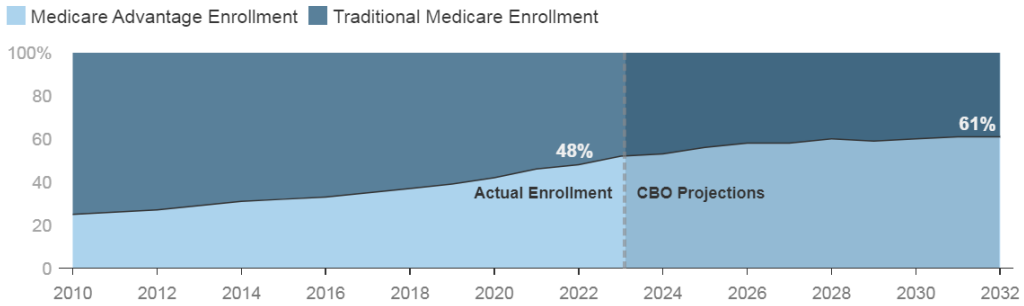
MA & TRADITIONAL MEDICARE ENROLLMENT (PAST AND PRESENT)



NOTE: Medicare enrollment is based on individuals who are enrolled in Part B, according to the CBO baseline. This is designed to include only individuals who are eligible for Medicare Advantage and exclude those who only have Part A only (~5 million people in 2023) and cannot enroll in Medicare Advantage. However, it may include some individuals who have Part B only and also are not eligible for Medicare Advantage.
SOURCE: KFF analysis Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2017; CCW data from 20 percent of beneficiaries, 2018; and Medicare Enrollment Dashboard 2019-2022. Enrollment numbers from March of the respective year. Projections for 2023 to 2030 are from the May Congressional Budget Office (CBO) Medicare Baseline for 2022. • PNG

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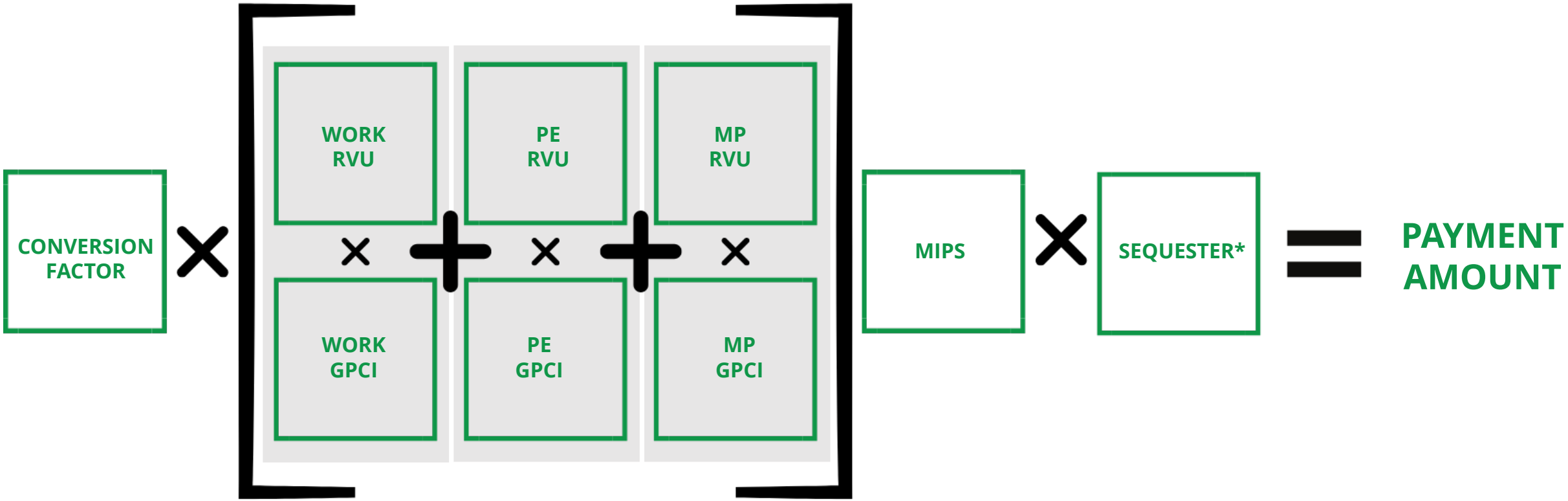
PHYSICIAN PAYMENT

MEDICARE SERVICE PAYMENT CALCULATION



MEDICARE PHYSICIAN PAYMENT

WHAT DOES THE FUTURE LOOK LIKE?

- Congress examining reform
  - House Energy & Commerce MACRA hearing in June 2023 (*See MGMA's testimony*)
  - QPP & AAPMs

MGMA'S POSITION:

- Provide annual inflation-based physician payment update based on the Medicare Economic Index (MEI)
- Provide positive financial incentives to support the transition to value-based care
- Oppose efforts to use sequestration and PAYGO rules to offset unrelated congressional spending
- Advance policies that incentivize and reward providers to reduce total cost-of-care

VIEW MGMA'S POSITION PAPER ON PHYSICIAN PAYMENT HERE

2024 MEDICARE PHYSICIAN FEE SCHEDULE

PROPOSED RULE

- Setting 2024 Medicare payment rates for physician services. For 2024, CMS proposes a Conversion Factor of $32.7476 and $20.4370 for Anesthesia (a decrease of -3.4% and -3.3%, respectively, over final 2023 rates);
- Extending flexibilities to permit split/shared E/M visits to be billed based on one of three components (history, exam, or medical decision making) or time through at least 2024, following MGMA advocacy;
- Reimbursing telehealth services furnished to patients in their homes at the typically higher, non-facility PFS rate;
- Continuing to allow direct supervision by a supervising practitioner through real-time audio and video interaction telecommunications through 2024;
- Continuing coverage and payment of telehealth services included on the Medicare Telehealth Services List through 2024;
- Pausing implementation and rescinding the Appropriate Use Criteria program regulations;
- Increasing the performance threshold from 75 points to 82 points for all three MIPS reporting options;
- Adding five new MIPS Value Pathways related to women's health, prevention and treatment of infectious disease, quality care in mental health/substance use disorder, quality care for ear, nose, and throat, and rehabilitative support for musculoskeletal care;
- Making numerous changes to the Medicare Shared Savings Program (MSSP) such as revising the MSSP quality performance standard, modifying the program’s benchmarking methodology, and determining beneficiary assignment under the MSSP; and,
- Ending the 3.5% APM Incentive Payment after the 2023 performance year/2025 payment year, and transitioning to a Qualifying APM Conversion Factor in the 2024 performance year/2026 payment year.

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TIMELINE

PROPOSED PFS RELEASED

COMMENTS DUE TO CMS

FINAL PFS RELEASED

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PROPOSED 2024 CONVERSION FACTORS

Calculation of CY 2024 PFS Conversion Factor		
CY 2023 Conversion Factor		33.8872
Conversion Factor without the CAA, 2023 (2.5% Increase for CY 2023)		33.0607
CY 2024 RVU Budget Neutrality Adjustment	-2.17% (0.9783)	
CY 2024 1.25 Percent Increase Provided by the CAA, 2023	1.25 percent (1.0125)	
CY 2024 Conversion Factor		**32.7476**

CY 2023 Anesthesia Conversion Factor		
CY 2023 National Average Anesthesia Conversion Factor		21.1249
Conversion Factor without the CAA, 2023 (2.5% Increase for CY 2023)		20.6097
CY 2024 RVU Budget Neutrality Adjustment	-2.17% (0.9783)	
CY 2024 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	0.11% (1.0011)	
CY 2024 1.25% Increase Provided by the CAA, 2023	1.25% (1.0125)	
CY 2024 Conversion Factor		**20.4370**

SOURCE: PROPOSED 2024 PHYSICIAN FEE SCHEDULE

Calendar Year	Conversion Factor
2020	$36.0896
2021	$34.8931
2022	$34.6062
2023	$33.8872
2024 (proposed)	$32.7476

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EVALUATION & MANAGEMENT (E/M) SERVICES

ADD-ON CODE (HCPCS CODE G2211)

- **CMS proposes to implement G2211**
- 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. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established))

SPLIT/SHARED E/M

- **CMS again proposes to delay the implementation of the definition of "substantial portion" for purposes of split/shared billing.** In 2024, the agency proposes to continue to permit the substantial portion of the E/M service to be defined as either history, exam, MDM, or more than half of total time.

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BEHAVIORAL HEALTH

MARRIAGE AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS

- Proposes definitions for Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC) and establishes that MFTs and MHCs can now receive payment
- Payment for CSW, MFT, and MHC services will be 80% of the lesser of the actual charge for the services or 75% of the amount determined for clinical psychologist services under the PFS

HEALTH BEHAVIOR ASSESSMENT AND INTERVENTION SERVICES

- Allows Health Behavior Assessment and Intervention (HBAI) services (CPT codes 96156, 96158, 96159, 96164, 96165, 96167, 96168) to be billed by CSWs, MFTs, and MHCs in addition to clinical psychologists

INCREASED VALUATION FOR TIMED BEHAVIORAL SERVICES

- Implement increased valuation for timed behavioral health services over four years by applying an adjustment to the work RVUs for psychotherapy codes payable under the PFS

CRISIS CODES

- New HCPCS codes under the PFS for psychotherapy crisis services provided in non-office settings
- Payment for these services would be set at 150% of the PFS amount for non-facility sites of service

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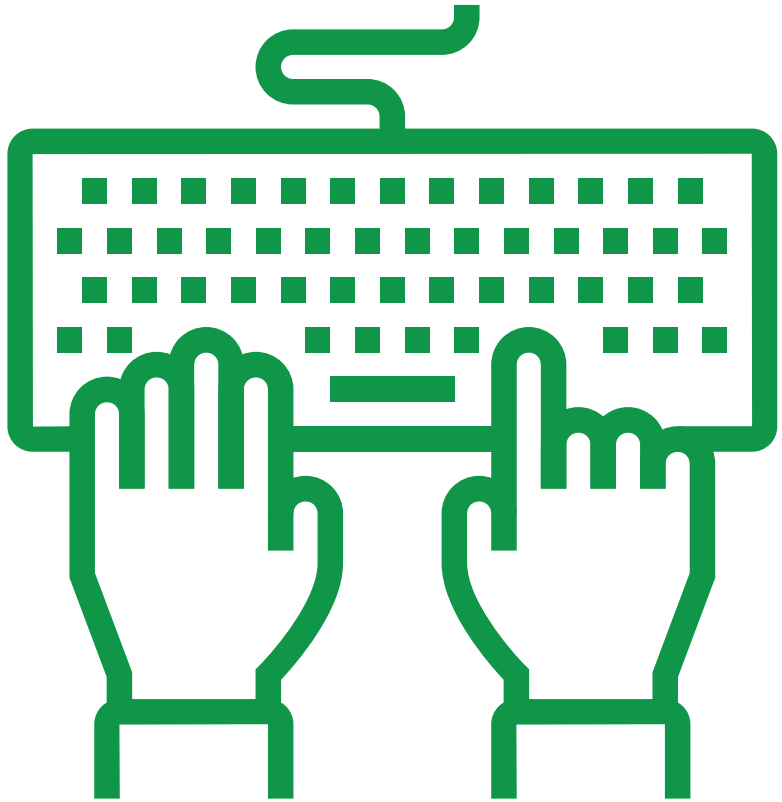
ELECTRONIC PRESCRIBING FOR CONTROLLED SUBSTANCES

- CMS proposes to further modify the recognized emergency exception and extraordinary circumstances waiver and align the determination of the emergency exception with the MIPS automatic extreme and uncontrollable circumstances policy

- CMS proposes to continue issuing prescriber notices of non-compliance rather than financially penalizing clinicians who fail to meet the requirements



OCCUPATIONAL THERAPIST AND PHYSICAL THERAPIST SUPERVISION

- Historically, CMS requires that all physical therapy (PT) and occupational therapy (OT) services be under the direct supervision of PTs and OTs in private practice

- For 2024, CMS proposes allowing physical therapy assistants and occupational therapy assistants in private practices to furnish RTM services when under the general supervision of the PT or OT

PROVIDER ENROLLMENT

- Adds the conviction of a misdemeanor under Federal or State law within the previous 10 years as a reason for revocation
- Requires all Medicare providers and suppliers to report additions, deletions, or changes in their practice locations within 30 days
- Proposes a new enrollment status – “stay of enrollment” – as an interim status determined by the agency on a case-by-case basis used to delay revocation or deactivation of billing privilege for paperwork mistakes or missed deadlines for 60 days

TELEHEALTH

- Implement provisions from the CAA, 2023
- Removal of frequency limitations (CPT codes 99231, 99232, 99233, 99307, 99308, 99309, 99310, G0508, G0509)
- Non-facility rates for telehealth (POS 10)
- Changes to **Medicare Telehealth Services List**
- New process to add codes to list
- Allow direct supervision via audio/video communications technology

MEDICARE TELEHEALTH WAIVER TIMELINE

TELEHEALTH POLICY	PRE-PHE POLICY	PHE POLICY	DATE POLICY ENDS & REVERTS TO PRE-PHE
Originating site/geographic location	Beneficiaries must receive services at originating site in a rural area (not the home)	Location is waived – patients can be seen anywhere	Dec. 31, 2024 ***exception: mental health services*
Qualifying providers	Certain providers are allowed to deliver telehealth services	Provider types extended to PTs, OTs, and SLPs	Dec. 31, 2024
Audio-only services	CMS did not cover audio visits without a visual component	CMS will reimburse for services via phone (E&M visits)	Dec. 31, 2024
FQHCs and RHCs	FQHCs and RHCs could not qualify as distant site providers	Can qualify as distant site providers	Dec. 31, 2024
Payment parity	Telehealth services were reimbursed at typically lower, facility rates	Telehealth can be reimbursed at in-person rate if modifier 95 is used	Dec. 31, 2023
Cross-state licensure	Providers must be licensed in state where patient is located	If providers meet four conditions, can treat patients in other states (still must comply with state licensure requirements)	State specific
HIPAA compliant platforms	Providers must use HIPAA compliant platforms	Providers could use non-HIPAA compliant platforms so long as not public-facing	Aug. 9, 2023
Requirements for telehealth prescriptions	Required in-person evaluation before prescribing controlled substances via telehealth	Waived in-person requirement	Nov. 11, 2023 (Nov. 11, 2024 for patient-provider relationships established during COVID-19 PHE)

DOWNLOAD MGMA'S TELEHEALTH MEMBER RESOURCE HERE

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MEDICARE TELEHEALTH

MGMA SUPPORTS MEDICARE TELEHEALTH REFORM POST COVID-19

MGMA is urging Congress to:

- Remove geographic and originating site restrictions
- Allow permanent coverage of audio-only services
- Reimburse telehealth visits at an appropriate rate

VIEW MGMA'S POSITION PAPER ON TELEHEALTH HERE

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

- Establishes the Medicare CQMs for ACOs in MSSP as a new collection type
- Attempts to reduce to the impact of negative geographic adjustments in CMS' benchmarking methodology
- Makes changes to beneficiary assignment such as adding a third step with an expanded assignment window in 2025
- Removes the current CEHRT threshold requirements and changes promoting interoperability reporting policies

QPP - MIPS

- Increase in performance threshold from 75 (2023) to 82 points (2024)
- Negative payment adjustment up to -9% (CMS estimates 54% of clinicians)

QUALITY (30%)	COST (30%)	IA (15%)	PI (25%)
• 200 quality measures • Requirement to contract with a CAHPS to administer Spanish survey translation	• Calculate improvement scoring at the category level (not measure level) • 5 new episode-based cost measures (20-episode case minimum) • Maximum cost improvement score of 1 pt will be available in 2023 performance period, 0 pts in 2022	• 5 new IA • Remove 3 current IA • Modify 1 existing IA	• Move away from "editions" of certification criteria • Lengthen performance period from 90 to 180 days

QPP- MVPs

- Consolidate the Promoting Wellness and Optimizing Chronic Disease MVPs into one primary care MVP
- Makes changes to subgroup reporting requirements

PROPOSES FIVE NEW MVPS FOR REPORTING IN 2024:

- 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.

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QPP - APMs

- Removes the 75% requirement for CEHRT use by eligible clinicians in an APM Entity and require all eligible clinicians to use CEHRT in 2024
- The 3.5% APM incentive bonus is set to expire after 2023; for 2024, QPs will receive a "qualifying AP conversion factor" of 0.75% compared to non-QPs who will receive a 0.25% PFS update
- The QP threshold for Medicare payments will increase from 50% to 75%, while the partial QP threshold will increase from 40% to 50%
- The Medicare patients QP threshold will increase from 35% to 50% and the partial QP threshold will increase from 25% to 35%
- Makes QP determinations at the individual level instead of the APM Entity level

PRIOR AUTHORIZATION

2023 MGMA PRIOR AUTHORIZATION SURVEY

OVER 600 RESPONDENTS

77%

of respondents have had to hire additional staff or redistribute staff to work on increased PA requests

30%

of respondents must interface with 11 or more health plan proprietary portals for prior authorization requests

72%

of respondents report there is not a health plan clinician from a relevant specialty when completing peer-to-peer reviews

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PRIOR AUTHORIZATION REFORM

CURRENT POLICY LANDSCAPE

We are finally seeing a serious interest from this Administration to address aspects of prior authorization reform. CMS has conducted in-person meetings, published proposed rules aimed at reform, and engaging with provider group stakeholders.

VIEW MGMA'S POSITION PAPER ON PRIOR AUTHORIZATION HERE

PROPOSED PA CHANGES FROM CMS

MEDICARE ADVANTAGE & PART D RULE (MGMA COMMENTED FEB. 10, 2023)

- Rule finalized in April 2023, incorporating many of MGMA's recommendations
- CMS proposed changes to the prior authorization for MA plans following a 2022 OIG report that raised concerns about MA prior authorization denials
- The rule would revise standards for coverage, regulate the use of PA, and establish a utilization management committee

PRIOR AUTHORIZATION & INTEROPERABILITY RULE (MGMA COMMENTED MAR. 13, 2023)

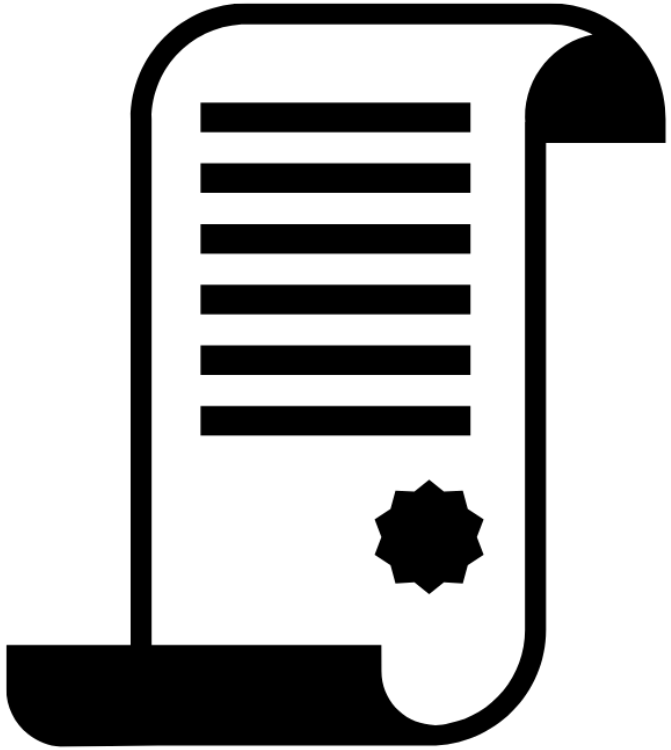
- CMS proposed to reform aspects of prior authorization within the MA program along with several govt. payers
- The rule requires affected payers to publicly publish aggregated prior authorization data, implement a process to facilitate electronic prior authorizations, shorten timeframes for returning prior authorization decisions, and provide specific reasons for prior authorization denials

HIPAA ATTACHMENTS RULE (MGMA COMMENTED APRIL 21, 2023)

- CMS proposed to establish electronic attachment standards for claims and prior authorization transactions

PRIOR AUTHORIZATION

MGMA SUPPORTS IMPORTANT UPDATES TO REFORM PRIOR AUTHORIZATION



IMPROVING SENIORS' TIMELY ACCESS TO CARE ACT

- Requires MA plans to support electronic prior authorization;
- Requires MA plans to make real-time prior authorization decisions; and,
- Requires MA plans to make certain information available, such as a list of all applicable items and services subject to prior authorization requirements and the percentage of prior authorization requests approved

MGMA HELPED WRITE THIS BILL!

SITE OF SERVICE DIFFERENTIALS

SITE OF SERVICE DIFFERENTIALS

MEDICARE PAYS PROVIDERS DIFFERENTLY DEPENDING ON WHERE CARE IS DELIVERED

Payment rates for outpatient services furnished in hospital facilities are higher than rates paid to physician offices for providing the same service. The scope of the payment differential varies, depending on the procedure or service.

- Services provided in a hospital outpatient department (HOPD) are paid for under the Outpatient Prospective Payment System (OPPS). The payment for the HOPD services is comprised of a reduced Physician Fee Schedule (PFS) payment + a facility fee under OPPS.

- For services provided in a physician office, payment for services provided under the Physician Fee Schedule (PFS). The PFS does not account for the cost of inflation.

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SITE OF SERVICE DIFFERENTIALS

BACKGROUND

- Higher payment for HOPDs incentivized the sale of physician practices to hospitals. If a physician office was 35 miles away from a hospital and was acquired by that hospital, it could be converted to a HOPD and start receiving the PFS+OPPS facility fee (higher payments)
- In 2015, the *Bipartisan Budget Act* implemented site neutral payments. Required HOPDs be paid under the PFS rather than OPPS
    - This only applied to HOPDs that were acquired after Nov. 2, 2015
- In 2017, the *21st Century Cures Act* added site-neutral payment exemption rules that would allow some developing off-campus provider-based hospital departments to continue billing under OPPS

CONGRESS IS SHOWING INTEREST IN SITE NEUTRAL POLICIES

- Congress and MedPAC have been discussing site neutral policies in the wake of Medicare insolvency and increasing consolidation
- It is currently unclear whether this legislation will move forward. MGMA will continue to monitor the impact of site neutral legislation for medical group practices

HEALTH IT UPDATE

HIPAA PRIVACY RULE

PROPOSED UPDATE

The HHS Office for Civil Rights (OCR) proposed an update to the HIPAA Privacy Rule which would:

- Allow individuals to take notes or use other personal resources to view and take pictures of their PHI
- Shorten covered entities' required response time to no later than 15 calendar days with the opportunity for an extension of no more than 15 calendar days
- Specify when electronic PHI must be provided to the individual at no charge
- Eliminate the requirement for a covered healthcare provider with a direct treatment relationship with an individual to obtain a written acknowledgement of the receipt of the NPP

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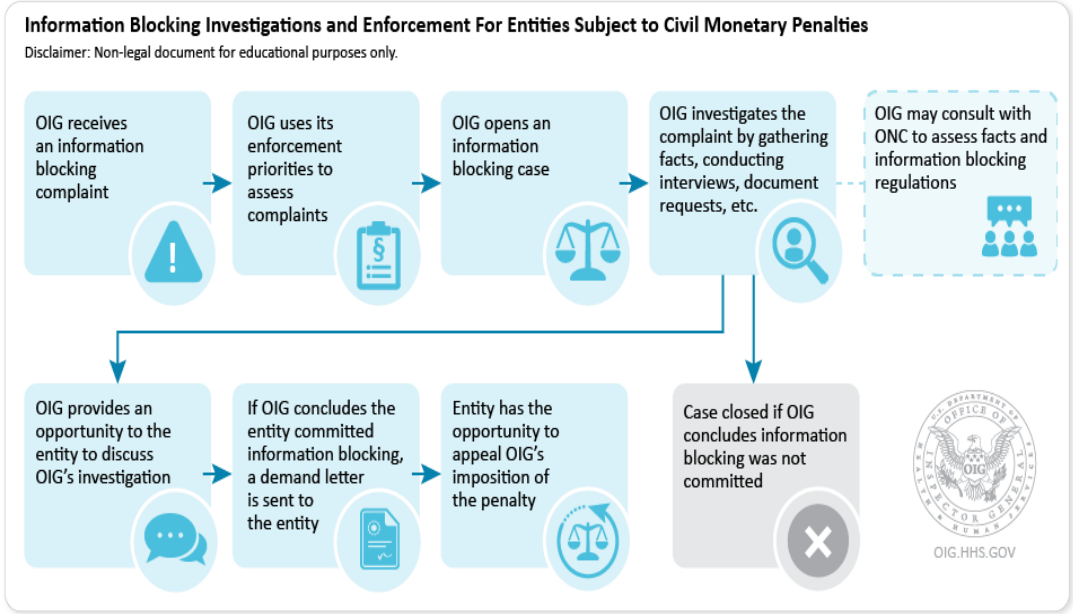
INFORMATION BLOCKING

UPDATES ON PENALTIES

- **Penalties for Providers**
  - Subject to "appropriate disincentives"
  - Likely rulemaking in the fall
- **Penalties for Developers**
  - Enforcment begins Sept. 1, 2023
  - Up to a $1 million penalty per violation
- ONC put forward additional exceptions in a recent proposed rule



Source: https://oig.hhs.gov/reports-and-publications/featured-topics/information-blocking/

DEA TRAINING REQUIREMENT

MATE ACT

TRAINING REQUIREMENT

- The *Medicare Access and Training Expansion (MATE) Act* was included in the *Consolidated Appropriations Act of 2023*
- All DEA-registered practitioners are required to undergo a one-time, eight-hour training requirement as of June 27, 2023:
  - Training must be related to opioid or substance use disorder management or treatment
  - Must be completed before the practitioner's initial or next renewal registration on or after June 27, 2023
  - Practitioners will be required to attest on their next registration that they completed the training

MATE ACT CONT.

NUMEROUS OPTIONS TO COMPLETE THE TRAINING

- Board certified in addiction medicine or addiction psychiatry from the American Board of Addiction Medicine, American Board of Medical Specialties, American Osteopathic Association
- Graduated in good standing from medical, dental, physician assistant, or advanced practice school within five years of June 27, 2023, and completed a comprehensive curriculum with eight hours of training
- Eight hours of training from an accredited group
  - Doesn't have to occur in one session
  - Past trainings count prior to the enactment of the new training obligation on Dec. 29, 2022
  - Past DATA-Waiver trainings count
  - Can occur in a variety of formats

BIG PICTURE

IN SUM…

- CMS will release 2024 Medicare payment policies (PFS) by Nov. 1
- If Congress addresses Medicare cuts, we expect that to happen at the end of the year in a larger package
- Conversations are ongoing with stakeholders & policymakers regarding the future of Medicare payment — likely will not be resolved in 2023
- Permanent telehealth reform will likely not be addressed in 2023

ADVOCACY & MEMBER ENGAGEMENT

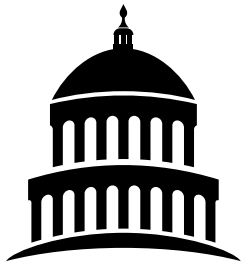
118TH CONGRESS - BILLS

MGMA SUPPORTS LEGISLATION TO SUPPORT MEDICAL GROUPS

- Medicare Economic Index (MEI)
- Telehealth expansion
- Chronic care management (CCM)
- Preventing Medicare lab cuts (SALSA)
- Graduate Medical Education (GME)

GET INVOLVED… SEND A LETTER TODAY!

MGMA GOVERNMENT AFFAIRS RESOURCES



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SPEAK DIRECTLY TO MGMA GA EXPERTS

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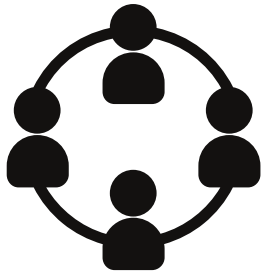

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