2024 Medicare Physician Fee Schedule Highlights: Advancing Innovation and Equity

Insights 12.05.23

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On November 16, 2023, the Centers for Medicare & Medicaid Services (CMS) published the physician fee schedule final rule for calendar year 2024 (CY 2024 PFS FR). As always, the rule covers a lot of ground with respect to Medicare Part B policies. In particular, CY 2024 will be pivotal for policies advancing innovation in care delivery, through continued emphases on virtual care and addressing health-related social needs. Some of the key takeaways follow.

Medicare Telehealth Services

New Coverage of Virtual Health Coaching and Social Determinants of Health (SDOH) Risk Assessments

The CY 2024 PFS FR establishes temporary coverage of three CPT codes for Health and Well-being Coaching Services, as CMS has "open questions" regarding the clinical benefits of virtual health coaching services. Nevertheless, the inclusion of health coaching services, even on a temporary basis, is noteworthy as Medicare has not covered such services historically, and coaching has become widely utilized across the health care delivery spectrum in recent years. This welcome development for Medicare beneficiaries will, however, be a short-lived victory if these codes are not covered permanently beyond 2024.

CMS also finalized its decision to cover a HCPCS code for administering a standardized evidence-based SDOH risk assessment in connection with an E/M visit (discussed in more detail later in this article) on a permanent basis. That decision is consistent with recent efforts to advance health equity across the Department of Health and Human Services and the current Administration more broadly. While CMS does not require the use of a specific instrument, they do expect that the instrument will be validated, and points to examples, such as that used in the Accountable Health Communities CMMI model.

Clarity on MFTs and MHCs as Telehealth Practitioners, Telehealth Frequency Limitations

Starting in CY 2024, CMS will permanently recognize marriage and family therapists and mental health counselors as telehealth practitioners.

During the PHE, the frequency limitations for certain services on the Medicare Telehealth Services List were removed. That flexibility ended at the end of the PHE, at which point CMS stated it would exercise enforcement discretion through CY 2023. Here, CMS makes clear that it will not enforce such frequency limitations in CY 2024.

Extending PHE Telehealth Flexibilities Through the End of CY 2024

As we covered at several points throughout the COVID-19 public health emergency (PHE) (see here, for example), Congress and CMS established significant flexibilities involving telehealth for Medicare beneficiaries during the PHE, including: (i) removing restrictions on telehealth originating sites, which allowed patients located anywhere in the U.S. (including their homes) to access services; (ii) expanding the definition of eligible practitioners to include occupational therapists, qualified physical therapists, qualified speech-language pathologists and qualified audiologists; (iii) delaying the requirement for an in-person visit within 6 months prior to initiating mental health telehealth services to a beneficiary in their home and in subsequent intervals; and (iv) continuing payment of services on the Medicare Telehealth Services List, including those via an audio-only telecommunications system. These policies were extended through the end of CY 2024 through the 2023 Consolidated Appropriations Act (CAA), and the CY 2024 PFS FR implements these policies, and CMS makes clear that it has little if any recourse beyond December 31, 2024 since that date is statutory.

Physicians Do Not Need to List Their Home Address (For Now)

Historically, CMS has required practitioners to include their practice location in Medicare enrollment paperwork, which is publicly accessible. As many providers began treating patients while physically located at home via telehealth during the PHE, concerns emerged regarding the privacy and safety of those providers' home addresses being publicly available. In the CY 2024 PFS FR, CMS finally clarified that it will *not* require practitioners to include their home addresses when providing care via telehealth. However, like so much of current policy surrounding telehealth and the Medicare program, that extension is only valid until the end of CY 2024. CMS has asked for "clear examples of how the enrollment process shows material privacy risks to inform future enrollment and payment policy development" so that they can consider this issue in future rulemaking.

In-Person Requirements for Mental Health Services Beyond CMS' Authority

In response to industry concerns that CMS has declined to extend telehealth flexibilities and has added "significant qualifiers, including in-person requirements, to mental health services," CMS reminds stakeholders that only Congress can modify the statutory in-person visit requirement for mental health services established through the 2021 CAA. CMS has not yet enforced these requirements because Congress delayed them for the past 2 years, in the 2022 CAA and the 2023 CAA, though it will enforce them in the future as directed by Congress with two narrow exceptions. Extending these telehealth flexibilities further is beyond the purview of CMS and would require Congressional intervention.

Telehealth Services Furnished to Patients at Home to be Paid at Non-Facility Rate

During the PHE, practitioners were instructed to report the place of service (POS) code they would have reported had the service been furnished in-person and use modifier "95" to indicate if the service was provided via telehealth, as opposed to the telehealth POS codes (*i.e.*, POS 02 for telehealth provided other than in the patient's home, and POS 10 for telehealth provided in the patient's home). This meant that office visits that were furnished to the patient at home, when they would regularly be provided in an office setting, were billed using an office POS at the PFS non-facility rate, which is higher than the facility rate for services billed within, for instance, the four walls of a hospital. In the CY 2024 PFS FR, CMS finalized its proposal to continue paying practitioners for telehealth services provided in the patient's home at the non-facility rate going forward (*i.e.*, when billed with POS 10), which is a welcome development for stakeholders looking to maintain momentum for their telehealth programs while continuing to incur the typical practice expenses to maintain an office for in-person visits. CMS also clarifies that when a clinician is in a hospital and provides services via telehealth to a patient at home, the practitioner should use the hospital POS code along with modifier "95." In addition, physical therapy, occupational therapy, and speech-language pathology distant site practitioners furnishing outpatient therapy services should continue to use the "95" modifier to identify as telehealth services rather than using a telehealth POS code.

Streamlining the Process of Covering New Telehealth Services

Prior to the CY 2024 PFS FR, when services were added to CMS's Medicare Telehealth Services List they were placed in one of three categories: (i) Category 1 – services similar to those already on the list; (ii) Category 2 – services that are not similar to those already on the list, for which CMS determines there is a clinical benefit when using a telecommunications system; and

(iii) beginning in 2021, Category 3 – services added on a temporary basis, for which there is not sufficient evidence of a clinical benefit to support adding them permanently to Categories 1 or 2. CMS is now simplifying the process. Starting in CY 2024, Categories 1 and 2 will be classified as "permanent," and Category 3 as "provisional." CMS will follow a 5 step process, going forward to determine whether a service is permanent, provisional, moved from provisional to permanent or dropped.

Caregiving Training Services

CMS recognizes that caregivers can play a key role in developing and implementing a treatment plan, as part of a goal of care coordination and team-based care. Starting in CY 2024, CMS will provide reimbursement to a treating practitioner when they identify a need to train a caregiver to assist the patient in carrying out their treatment plan, and engage in such training. The patient would not be present during this service, as it is a service focused on the caregiver, but the patient must provide consent. The service is billable as part of the patient care plan and may be repeated as the care plan is revised or as deemed necessary by the treating practitioner per beneficiary, regardless of the number of caregivers that receive training. However, there is a CPT code that accounts for group training of multiple caregivers. The frequency of the services should be reasonable and necessary based on the treatment plan and any changes in the treatment plan, the patient's condition, the patient's diagnosis, or the patient's caregivers.

CMS acknowledges this is a departure from its historical position that "Medicare does not pay for services furnished to parties other than the patient," including communication with caregivers. CMS references support for caregiver training "as a component of the standard of care for the treatment of certain social determinants of health (SDOH) behavior issues and that this training promotes improved outcomes." This new reimbursement scheme is a recognition of the important role family members or other caregivers could play as part of a patient's overall care.

Services Addressing Health-Related Social Needs

CMS is adding codes for the services listed below as a way to better value the work of practitioners helping patients with serious illnesses navigate the health care system or remove health-related social barriers to the implementation of a plan of care. In doing so, CMS has expressly affirmed:

"Medical practice has evolved to increasingly recognize the importance of these activities, and we believe practitioners are performing them more often. However, this work is not explicitly identified in current coding, so we believe it is underutilized and undervalued. We expect that our new codes would also support the CMS pillars for equity, inclusion, and access to care for the Medicare population and improve patient outcomes, including for underserved and low-income populations where there is a disparity in access to quality care."

CMS notes that the American Medical Association has recognized in its CPT E/M guidelines that social determinants of health (SDOH) needs can increase complexity of medical decision making and can increase patient risk when diagnosis or treatment is limited by SDOH, meaning economic and social conditions that influence the health of people and communities. Examples include food, housing, or transportation insecurity and unreliable access to public utilities. In doing so, CMS recognizes that often social workers, community health workers, or other auxiliary personnel perform these activities incident to the billing practitioner.

Community Health Integration Services

CMS is finalizing new codes for community health integration (CHI) services performed by certified or trained auxiliary personnel, including community health workers, incident to the billing practitioner's services. These services involve connecting the patient with resources to address SDOH needs that significantly limit a practitioner's ability to diagnose or treat problems addressed in an initiating E/M visit – the "initiating CHI visit." Services include a person-centered assessment (such as understanding the patient's life story, understanding cultural and linguistic factors, and assessing unmet SDOH needs), care coordination (such as coordinating receipt of needed services from community-based service providers and social service providers, and facilitating access to social services such as housing, utilities, transportation, and food assistance, to address SDOH needs), health education, building self-advocacy skills, navigation of the health care system,

providing social and emotional support, and leveraging lived experience to provide support, mentorship, or inspiration.

The billing practitioner of the initiating CHI visit must be the same billing practitioner for the subsequent CHI services, and patient consent is required. CMS lays out requirements for the use of auxiliary personnel, under general supervision, in the delivery of CHI. Other restrictions also apply. For example, CHI services cannot be billed when a patient is under a home health plan of care.

The ability to bill for CHI services is another example of an expansion of the types of services that can be reimbursed, as medical care has evolved. CMS provides an example for the use of CHI services in commentary which is telling in the ways that community health workers or other individuals providing social support can help move the needle on patient outcomes. In CMS's example, a primary care physician might order CHI services for a patient experiencing homelessness with signs of potential cognitive impairment and a history of emergency department visits due to uncontrolled diabetes. The physician has learned that the individual often loses medication when transitioning between shelters, and that housing insecurity leads to lack of medication adherence, which in turn leads to inadequate insulin control and more hospital visits. The CHI services could include facilitating communication with local shelters to identify a location to store medication while otherwise securing housing, identifying transportation assistance to facilitate access to the medication, and assisting with applying for and tracking the status of applications for local housing assistance.

Principal Illness Navigation Services

CMS is also finalizing new codes for principal illness navigation (PIN) services. These services are similar to CHI services, but focus on patients with serious, high-risk illnesses who may or may not have SDOH needs. These services focus on social aspects of care management, such as services to refer patients to supportive services and provide information about clinical trials. The PIN codes also include codes for peer support services, provided by certified peer support specialists, such as facilitating person-centered interviews to understand the patient's history and support needs, and building self-advocacy skills so the patient can effectively communicate their needs and goals to their care teams.

Many of the rules applicable to CHI services also apply to PIN services. For example, the billing practitioner of the initiating PIN visit must be the same billing practitioner for the subsequent PIN services, and patient consent is required. And as a complement to the caregiver training noted above, PIN services can include referral of a caregiver to services, including peer support services.

Notably, CMS did not add the CHI and PIN codes to the Medicare Telehealth Services List because they do not typically require a face-to-face interaction, and therefore are not "Medicare telehealth services." In practice, this means that the PIN and CHI services codes will not be subject to the statutory restrictions on "Medicare telehealth services."

Social Determinants of Health Risk Assessment

CMS is finalizing a new code for administering a standardized evidence-based SDOH risk assessment, which enables practitioners to determine whether there are SDOH needs impacting a patient's medically necessary care. The SDOH risk assessment must be furnished by the billing practitioner on the same day that they furnish an E/M visit, and must be reasonable and necessary to inform the patient's diagnosis and treatment plan established during the visit. The risk assessment can be billed once every 6 months. The practitioner can select the SDOH risk assessment tool that fits their needs, though it should include an assessment of food insecurity, housing insecurity, transportation needs, and utility difficulties. As discussed previously, CMS also added this new code to the Medicare Telehealth Services List.

CMS provides an example of administering an SDOH risk assessment in commentary, which is useful to understand how the code may work in practice. In the example, a practitioner discovers during an SDOH risk assessment for a patient presenting for diabetes management that the patient does not have reliable access to electricity, and as a result they cannot keep their insulin refrigerated. With this information, the practitioner could prescribe insulin that does not require refrigeration, enabling the patient to receive medically necessary care that is realistic and attainable despite their personal SDOH needs.

Conclusion

The provisions in the CY 2024 PFS FR reflect that CMS continues to recognize the value in expanding upon the traditional means and scope of care delivery and is prioritizing innovation in payment policies as a result. For telehealth, this will be a pivotal year as many of the flexibilities will sunset at the end of 2024, barring further Congressional action and related advocacy. Meanwhile, the addition of reimbursement for activities such as CHI and PIN services and SDOH risk assessments reflects a recognition of the importance of providing additional support in the social aspects of care management in order to improve patient outcomes. The concepts go hand in hand, as different means by which to support innovative care delivery that promotes access to services beyond the traditional, in-person office visit.

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