July 17, 2023

Welcome to the Academy's Quarterly Public Policy E-Briefing. You will find this and all previous Public Policy E-Briefs on the Academy website. Please contact Joy Chen at jchen@healthsperien.com or visit the Academy's Education page on the Academy website for additional information. As well, if you are facing policy issues related to COVID-19, please contact us and/or visit our resources here. Highlights in this quarterly e-brief include:

1. **Centers for Medicare and Medicaid Services (CMS) Releases Calendar Year (CY) 2024 Medicare Physician Fee Schedule and Quality Payment Program (QPP) Proposed Rule**
2. House Committee on Energy and Commerce Holds Hearing on MACRA’s Implementation and Remaining Challenges
4. CMS Announces Multi-State Initiative to Strengthen Primary Care
5. Centers for Medicare & Medicaid Services Innovation Center (CMMI) Publishes Strategy to Support High-Quality Primary Care
6. CMS Unwinds Mandatory COVID-19 Vaccination Requirement for Health Care Providers

## CMS Releases CY 2024 MPFS and QPP Proposed Rule

On July 13, CMS released (fact sheet here) their calendar year (CY) 2024 Medicare Physician Fee Schedule (MPFS) and Quality Payment Program (QPP) Proposed Rule. Notably, overall payment rates under the MPFS are proposed to be reduced by 1.25% in CY 2024 compared to CY 2023. CMS is also proposing significant increases in payment for primary care and other kinds of direct patient care. The proposed CY 2024 MPFS conversion factor is $32.75, a decrease of $1.14 (or 3.34%) from the current CY 2023 conversion factor of $33.89. Comments are due by September 11, 2023, and can be submitted here. The Academy will be preparing a comment letter in response to this proposed rule.

Key highlights from the proposed rule are outlined below. CMS is proposing to:

- **Caregiver Training Services**
  - Make payments when practitioners train and involve caregivers to support patients with certain diseases or illnesses and carrying out a treatment plan. CMS is proposing to pay for these services when furnished by a provider or therapist who can create an individualized treatment plan or therapy plan of care.

- **Services Addressing Health-Related Social Needs**
  - Pay separately for Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Primary Illness Navigation services to account for resources when clinicians involve community health workers, care navigators, and peer support specialists in furnishing medically necessary care.
  - Implement coding and payment for SDOH risk assessments to recognize when practitioners spend time and resources assessing SDOH that may be impacting their ability to treat the patient. Additionally, they are proposing to add the risk assessment to the annual wellness visit as an optional, additional element with an additional payment.

- **Evaluation and Management (E/M) Visits**
  - Implement a separate add-on payment for healthcare common procedure coding system (HCPCS) code G2211. This code will better recognize the resource costs associated with evaluation and management visits for primary care and longitudinal care of complex patients. The add-on code would not be billed with a modifier that denotes an office or outpatient evaluation and management visit that is itself unbundled from another service.

- **Telehealth Services**
  - Add health and well-being coaching services to the Medicare Telehealth Services List on a permanent basis for Community Health Integration and Social Determinants of Health Risk Assessments on a permanent basis.
  - Implement several telehealth-related provisions of the Consolidated Appropriations Act of 2023 (CAA, 2023)
  - Pay telehealth services furnished in the home at the non-facility MPFS rate to protect access to mental health and substance use telehealth services by aligning with telehealth-related flexibilities that were extended via the CAA, 2023.
  - 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.

- **Behavioral Health**
  - Allow addiction counselors that meet all of the applicable requirements to be a mental health counselor (MHC) to enroll in Medicare as MHCs. CMS is proposing to allow marriage and family therapists (MFTs) and MHCs to enroll in Medicare when the CY 2024 MPFS final rule is published, and they would be able to bill Medicare for services starting January 1, 2024 if they meet all of the requirements.
  - Pay the Health Behavior Assessment and Intervention (HBAI) services described by CPT codes 96156, 96158, 96163, 96165, 96167, and 96168, and any successor codes, to be billed by clinical social workers, MFTs, and MHCs, in addition to clinical psychologists.
Preventive Vaccine Administration

- Maintain the additional payment for the administration of a COVID-19 vaccine in the home. CMS is also proposing to extend this in-home additional payment to the administration of the other three preventive vaccines included in the preventive vaccine benefit — the pneumococcal, influenza, and hepatitis B vaccines — when provided in the home.

Medicare Shared Savings Program (MSSP)

- Establish the Medicare CQMs for Accountable Care Organizations (ACOs) participating in the MSSP (Medicare CQMs) under the Alternative Payment Model (APM) Performance Pathway (APP). ACOs would continue to have the option to report quality data utilizing the CMS Web Interface measures, or new collection type for Shared Saving Program ACOs under the Alternative Payment Model (APM) Performance Pathway (APP). ACOs would continue to have the option to report quality data utilizing the CMS Web Interface measures, or new collection type for Shared Saving Program ACOs under the Alternative Payment Model (APM) Performance Pathway (APP).
- Remove the MSSP certified electronic health record technology (CEHRT) threshold requirements beginning performance year 2024, and add a new requirement, for performance years beginning on or after January 1, 2024, that all MIPS and/or MIPS CQMs collection types.
- Modify the calculation of the proportion of assigned beneficiaries dually eligible for Medicare and Medicaid, and calculation of the proportion of assigned beneficiaries enrolled in the Medicare Part D low-income subsidy (LIS), to be based on the number of beneficiaries, rather than person years, for calculating the proportion of the ACO's assigned beneficiaries who are enrolled in LIS or who are dually eligible for Medicare and Medicaid, starting in performance year 2024.
- Modify the calculation of the regional component of the three-way blended benchmark update factor (weighted one-third accountable care prospective trend (ACPT), and two-thirds national-regional blend), for agreement periods beginning on January 1, 2024, and in subsequent years. The proposed approach would cap prospective HCC risk score growth in the ACO's regional service area between benchmark year three and the performance year.
- Apply the same CMS-HCC risk adjustment model (V28) used in the performance year for all benchmark years, when calculating prospective HCC risk scores to risk adjust expenditures used to establish, adjust and update an ACO's benchmark, for agreement periods beginning on January 1, 2024, and in subsequent years.
- Revise the step-wise beneficiary assignment methodology to include a new step three, which would utilize a proposed expanded window for assignment (a 24-month period that would include the applicable 12-month assignment window and the preceding 12 months) to identify additional beneficiaries for assignment. Consistent with the proposal to expand the expanded window for assignment in an enhanced step-wise.
- Allow ACOs to advance to two-sided model levels within the BASIC track's glide path, beginning in performance year of the agreement period in which they receive advance investment payments. The Agency is also proposing to offer advance investment payments from the shared savings of an ACO that wishes to renew early to continue its participation in the Shared Savings Program, instead of directly recouping the payments from the ACO.

House Committee on Energy and Commerce Holds Hearing on MACRA's Implementation and Remaining Challenges

On June 22, the House Committee on Energy & Commerce Subcommittee on Oversight & Investigations held a hearing examining Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)'s implementation along with the ongoing challenges it poses for providers and patients. Chairman Griffith (R-VA) provided opening remarks explaining that MACRA has provided many benefits since its enactment in 2015, such as eliminating the sustainable growth rate (SGR) model and transitioning from a fee-for-service system to that of value-based care through the merit-based incentive payment system (MIPS) and alternative payment models (APMs). During the hearing, discussion covered concerns about current reporting requirements and quality measures, with members calling requirements bureaucratic and overly burdensome, especially for small and rural practices. Several members raised the issues of inadequate provider reimbursement amidst provider shortages and advocated for legislation implementing an annual inflation update.

The hearing featured witness testimony from individuals representing the following organizations:

- Paragon Institute
- National Association of ACOs
- America's Physician Groups
- Austin Regional Clinic in Texas
- Warren Alpert Foundation Professor of Health Care
- Harvard Medical School Department of Health Care Policy

Healthsperien attended the hearing and full notes are available to view here.

Bipartisan Lawmakers Send Letter to CMS on Improving Prior Authorization Process

On June 21, more than 230 House members and 61 Senators sent a letter to CMS requesting changes to a December 2022 proposal that streamlines the prior authorization (PA) process for insurers and providers. The bipartisan group of lawmakers are led by Rep. Susan DelBene (D-WA) and request CMS to promptly finalize the rule and include provisions from DelBene's Improving S
Timely Access to Care Act to improve the prior authorization process for Medicare Advantage plans. The letter specifically asks to establish a mechanism for real-time electronic prior authorization decisions for routinely approved items and services, requires plans to respond to PA requests within 24 hours for urgent care, and require detailed transparency metrics.

The letter indicates that both the legislation and CMS's recent proposals would:

- **Establish an electronic PA (e-PA) process for MA plans**;

- **Accelerate PA decision time frames**;

- **Reduce the administrative burden for both providers and health plans**;

- **Increase transparency around PA requirements and clinical information needed to support decision-making**;

- **Expand beneficiary protections to improve patient experiences and outcomes**

**CMS Announces Multi-State Initiative to Strengthen Primary Care**

On June 8, CMS announced a new primary care model, the **Making Care Primary (MCP) Model**, that will be tested under CMMI states—Colorado, Massachusetts, Minnesota, New Jersey, New Mexico, New York, North Carolina, and Washington. The MCP will run for 10.5 years, from July 1, 2024, to December 31, 2034, and will provide participants with additional revenue to build infrastructure, make primary care services more accessible, and better coordinate care with specialists. The primary goals of the model are to:

- Ensure patients receive primary care that is integrated, coordinated, person-centered and accountable;

- Create a pathway for primary care organizations and practices—especially small, independent, rural, and safety net organizations—to enter into value-based care arrangements; and

- Improve the quality of care and health outcomes of patients, reducing program expenditure.

CMS is currently working with State Medicaid Agencies in the participating states to engage in full care transformation across programs, with plans to engage private payers in the coming months. The model includes a progressive three-track approach based on participants’ experience level with value-based care and alternative payment models. Track One will focus on building infrastructure to support care transformation. In Tracks Two and Three, the model will include certain advance payments and offer more opportunities for bonus payments based on participant performance.

**CMMI Publishes Strategy to Support High-Quality Primary Care**

On June 9, the Centers for Medicare & Medicaid Services Innovation Center (CMMI) released its strategy to support high-quality primary care. The strategy aims to strengthen the primary care infrastructure in the U.S. by creating multiple pathways to support improved financing for advanced primary care, equitable access to high-quality primary care, and sustainable transformations to reduce heterogeneity of practices.

The approach focuses on the following three dimensions:
The publication discusses current work addressing these areas, including Making Care Primary, the newest Innovation Center care model. The Innovation Center is also testing a new alignment strategy promoting payer partnership, alignment on key model design features, and encouraging payers to innovate for their unique patient population. The strategy also outlines future plans addressing the three focus areas. These efforts include exploring ACO-based primary care model tests that may focus on primary care the Shared Saving Program and exploring a state-based, total cost-of-care model.

CMS Unwinds Mandatory COVID-19 Vaccination Requirement for Health Care Providers

On May 31, CMS published a final rule withdrawing COVID-19 vaccination requirements for certain workers at CMS-covered healthcare facilities. On November 5, 2021, the Biden Administration and CMS issued an interim final rule (IFC) which required Medicare and Medicaid certified providers to be vaccinated against COVID-19. CMS recognizes that vaccines are important for preventing illnesses and promoting public health. However, CMS highlighted that the Agency has been evaluating its policies on an ongoing basis and that the incidence of severe COVID-19 has declined significantly since the IFC was issued. Thus, they are withdrawing the care staff COVID-19 vaccination provisions. CMS still strongly encourages facilities, when the opportunity exists and resources facilitate the vaccination and education of all individuals who provide services infrequently or frequently.

The American Academy of Home Care Medicine has been serving the needs of thousands of home care medicine professionals since 1988, through an interdisciplinary team of HBPC care providers working with patients’ community supports. Our members include home care physicians, nurse practitioners and physician assistants who make house calls, care for homebound patients, act as home health agency and hospice medical directors, and refer patients to home care agencies; home care organizations; medical directors of managed care plans; and administrators of medical groups interested in home care. Their specialties include internal medicine, family practice, pediatrics, geriatrics, psychiatry, and emergency medicine.

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