CSRO

CELEBRATING 20 YEARS

What has CMS done for you lately? MACRA and More

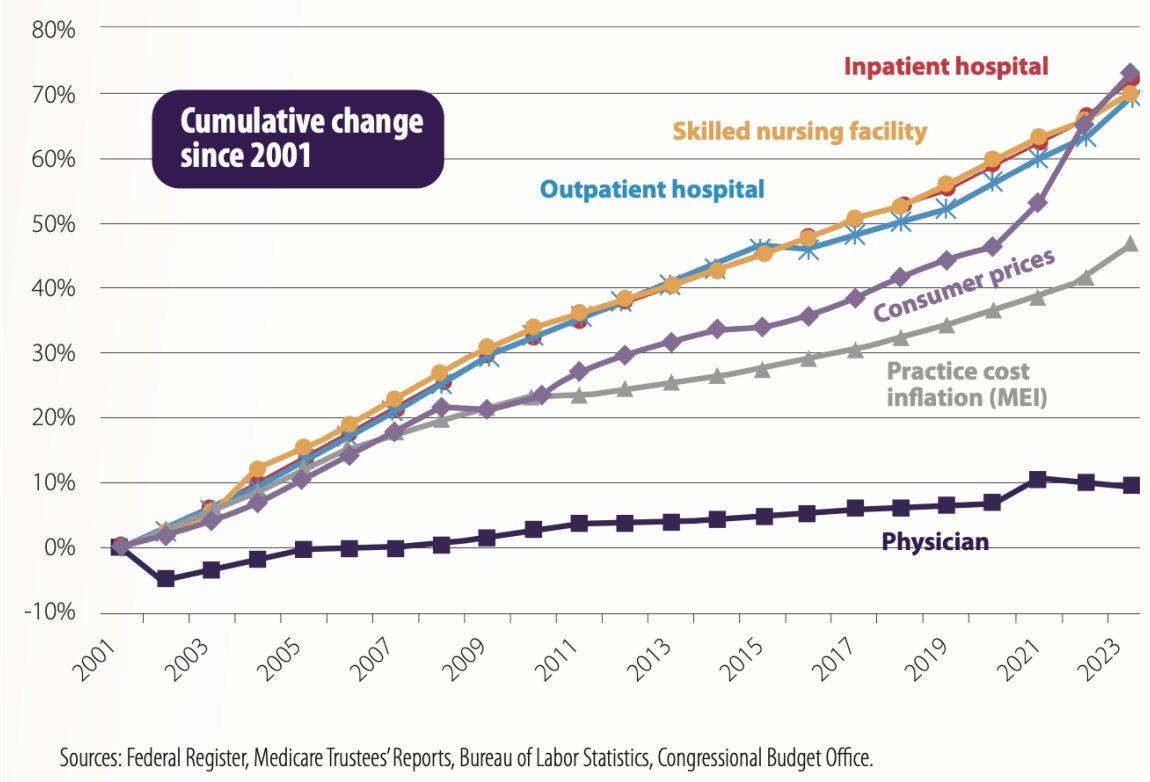
PRESENTER

Emily Graham – *Consultant to CSRO*

Medicare Physician Payment Update

CY 2024 Medicare Physician Fee Schedule (PFS)

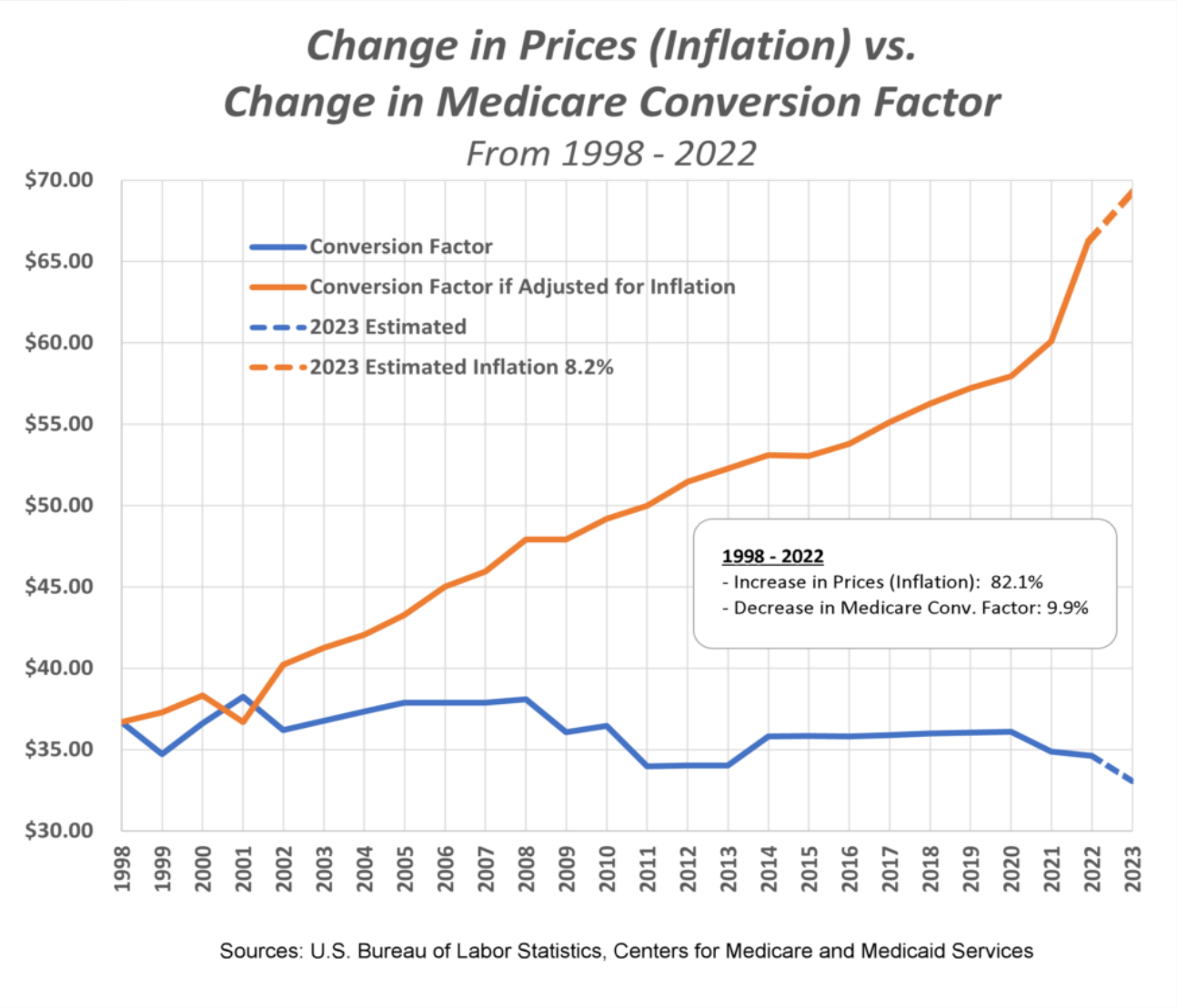
- CY 2024 PFS reflects a -3.34% cut to the conversion factor (~$32.7476)
  - Rheumatology pool increases by +2.0% due to favorable policy changes (i.e., complexity care add-on code, G2211)
- Ongoing Challenges in PFS payment
  - Flat, nominal base payment updates
  - No adjustment for inflation (i.e., Medicare Economic Index (MEI))
  - Inflexible budget neutrality requirements
  - Slow, irregular updates to key data inputs (e.g., practice expenses)



Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office.

*Celebrating **20 years** of serving as a **voice for the rheumatology community,** working to ensure patients have access to care.*

3



In 1998,
the conversion factor was

$36.69

Today,
the conversion factor is

$33.89

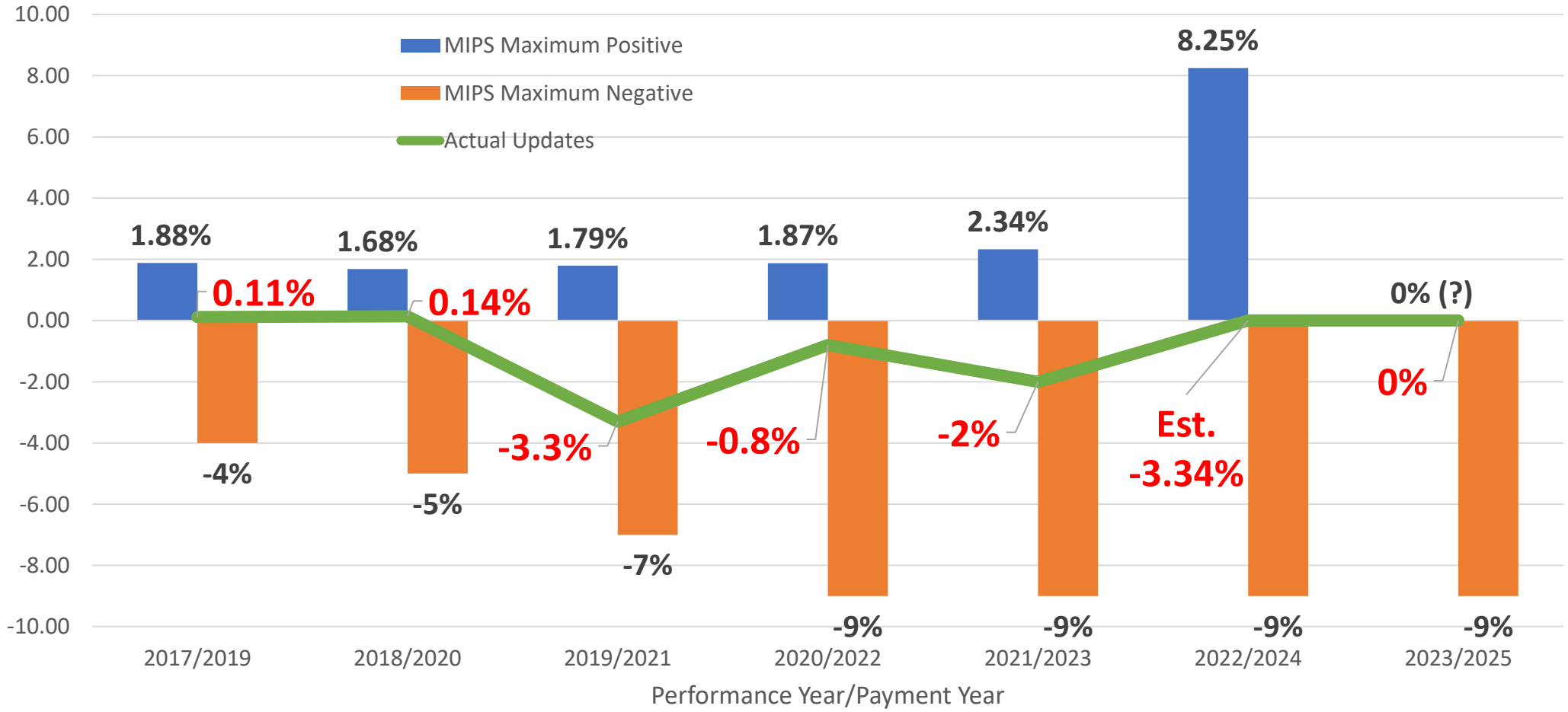
For CY 2024, CMS proposes the conversion factor to be

$32.75

Graph source: Frontier Institute

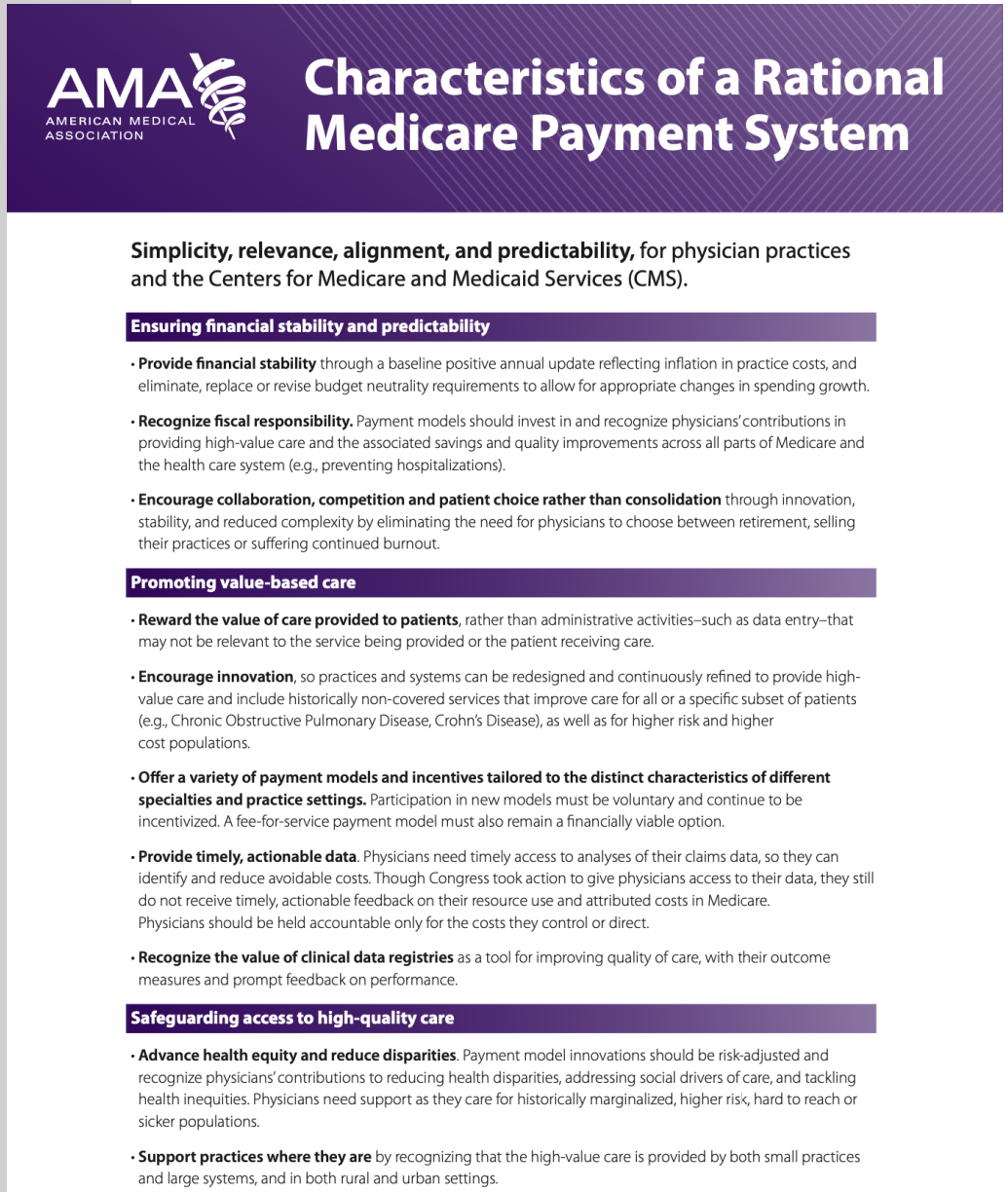
CSRO

Physician Payment Updates



*Celebrating **20 years** of serving as a **voice for the rheumatology community,** working to ensure patients have access to care.*

CSRO



AMA AMERICAN MEDICAL ASSOCIATION

Characteristics of a Rational Medicare Payment System

Simplicity, relevance, alignment, and predictability, for physician practices and the Centers for Medicare and Medicaid Services (CMS).

Ensuring financial stability and predictability

- **Provide financial stability** through a baseline positive annual update reflecting inflation in practice costs, and eliminate, replace or revise budget neutrality requirements to allow for appropriate changes in spending growth.
- **Recognize fiscal responsibility.** Payment models should invest in and recognize physicians' contributions in providing high-value care and the associated savings and quality improvements across all parts of Medicare and the health care system (e.g., preventing hospitalizations).
- **Encourage collaboration, competition and patient choice rather than consolidation** through innovation, stability, and reduced complexity by eliminating the need for physicians to choose between retirement, selling their practices or suffering continued burnout.

Promoting value-based care

- **Reward the value of care provided to patients**, rather than administrative activities–such as data entry–that may not be relevant to the service being provided or the patient receiving care.
- **Encourage innovation**, so practices and systems can be redesigned and continuously refined to provide high-value care and include historically non-covered services that improve care for all or a specific subset of patients (e.g., Chronic Obstructive Pulmonary Disease, Crohn's Disease), as well as for higher risk and higher cost populations.
- **Offer a variety of payment models and incentives tailored to the distinct characteristics of different specialties and practice settings.** Participation in new models must be voluntary and continue to be incentivized. A fee-for-service payment model must also remain a financially viable option.
- **Provide timely, actionable data**. Physicians need timely access to analyses of their claims data, so they can identify and reduce avoidable costs. Though Congress took action to give physicians access to their data, they still do not receive timely, actionable feedback on their resource use and attributed costs in Medicare. Physicians should be held accountable only for the costs they control or direct.
- **Recognize the value of clinical data registries** as a tool for improving quality of care, with their outcome measures and prompt feedback on performance.

Safeguarding access to high-quality care

- **Advance health equity and reduce disparities**. Payment model innovations should be risk-adjusted and recognize physicians' contributions to reducing health disparities, addressing social drivers of care, and tackling health inequities. Physicians need support as they care for historically marginalized, higher risk, hard to reach or sicker populations.
- **Support practices where they are** by recognizing that the high-value care is provided by both small practices and large systems, and in both rural and urban settings.

Characteristics of a Rational Medicare Payment System //////// 1

AMA Payment Reform Principles

Major tenets:

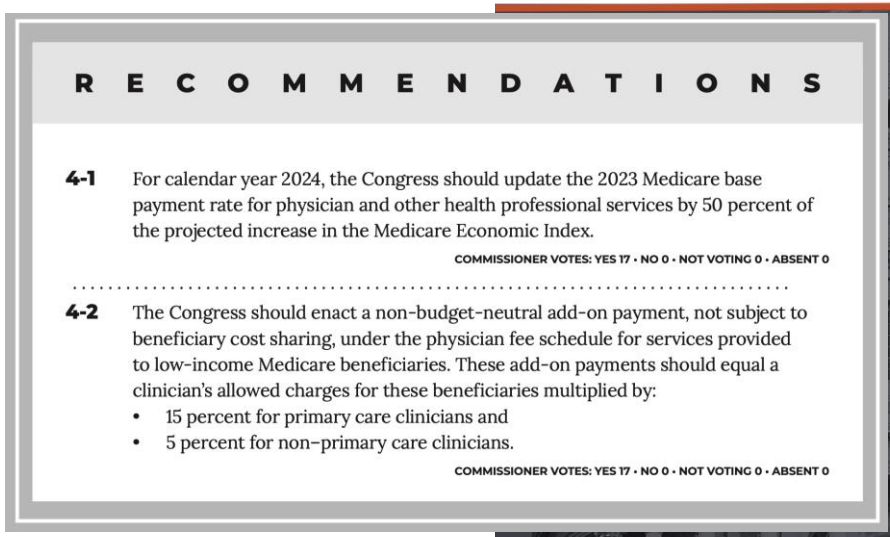
- Ensuring financial stability and predictability
- Promoting value-based care
- Safeguarding access to high-quality care

*Celebrating **20 years** of serving as a **voice for the rheumatology community,** working to ensure patients have access to care.*

CSRO

Medicare Payment Advisory Commission (MedPAC)

- MedPAC assesses Medicare physician payment adequacy based on metrics of:
  - *Access to care*
  - *Quality of care*
  - *Medicare payments and providers' costs*
- Despite positive access measures, the Commission recommended an update of ½ of the MEI for CY 2024 in March 2023



RECOMMENDATIONS

4-1 For calendar year 2024, the Congress should update the 2023 Medicare base payment rate for physician and other health professional services by 50 percent of the projected increase in the Medicare Economic Index.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

4-2 The Congress should enact a non-budget-neutral add-on payment, not subject to beneficiary cost sharing, under the physician fee schedule for services provided to low-income Medicare beneficiaries. These add-on payments should equal a clinician's allowed charges for these beneficiaries multiplied by:

- 15 percent for primary care clinicians and
- 5 percent for non-primary care clinicians.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Legislative Activity

Bills

- H.R. 2474, the *Strengthening Medicare for Patients and Providers Act*
  - Introduced by: Representatives Raul Ruiz, M.D. (D-CA-25), Larry Bucshon, M.D. (R-IN-08), Ami Bera, M.D. (D-CA-06), and Mariannette Miller-Meeks, M.D. (R-IA-01)
  - Provides an annual inflation update equal to the MEI for Medicare physician payments

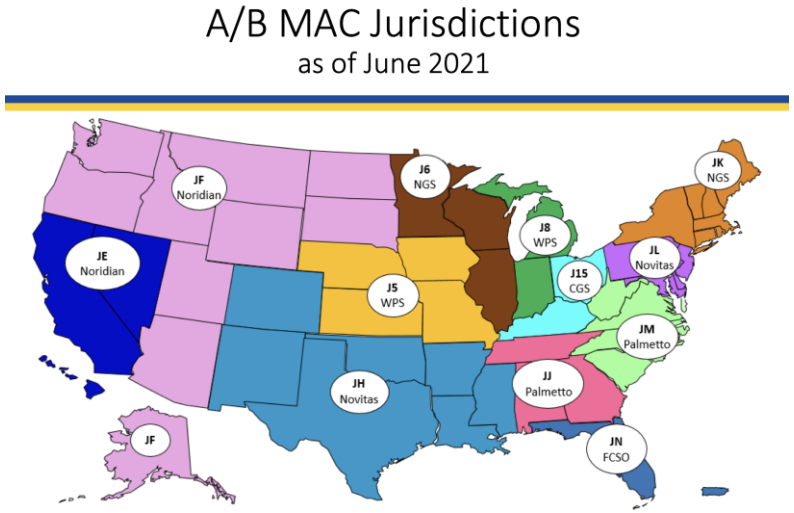
Hearings

- May 2019: Senate Finance Committee: "Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead"
- June 2023: House Energy & Commerce Oversight and Investigations Subcommittee Hearing: "MACRA Checkup: Assessing Implementation and Challenges that Remain for Patients and Doctors"

“Down Coding” and the “SAD” Exclusion List

Local Coverage and Payment Policy

- Medicare Administrative Contractor (MAC) have issued policies creating challenges for rheumatology practices
  - Complex drug administration "down coding"
    - "Billing and Coding" articles tell practices to use therapeutic administration codes for provision of highly complex biologics
    - Policies are contrary to coding guidelines and fail to account for practice costs
  - Self-Administered Drug (SAD) Exclusion List
    - MACs add medications to the SAD list without clearly showing how decisions are made
    - Drugs on SAD List are ineligible for payment under Part B, patient would be responsible in full
    - Policies are discriminatory, lack transparency



“Down Coding”

- Multi-year effort by CSRO to address problematic “down coding” of complex drug administration services
  - CSRO-led multi-provider coalition continues to engage and meet with CMS on policy options
- Multiple meetings with CMS staff and leadership led CSRO secured a “Technical Direction Letter” (TDL) that directs the MACs to “pause” down coding (August 12, 2022)
  - Substance is not publicly available, but CMS demonstrated willingness to assist
- MACs continue to educate practices based on flawed “Billing and Coding” LCAs
- Following CSRO advocacy, CMS issued a Request for Information (RFI) on this issue; CSRO and the coalition will submit formal response

Article - Billing and Coding: Complex Drug Administration Coding (A58527)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
Palmetto GBA	A and B MAC	10111 - MAC A	J - J	Alabama
Palmetto GBA	A and B MAC	10112 - MAC B	J - J	Alabama
Palmetto GBA	A and B MAC	10211 - MAC A	J - J	Georgia
Palmetto GBA	A and B MAC	10212 - MAC B	J - J	Georgia
Palmetto GBA	A and B MAC	10311 - MAC A	J - J	Tennessee
Palmetto GBA	A and B MAC	10312 - MAC B	J - J	Tennessee
Palmetto GBA	A and B and HHH MAC	11201 - MAC A	J - M	South Carolina
Palmetto GBA	A and B and HHH MAC	11202 - MAC B	J - M	South Carolina
Palmetto GBA	A and B and HHH MAC	11301 - MAC A	J - M	Virginia
Palmetto GBA	A and B and HHH MAC	11302 - MAC B	J - M	Virginia
Palmetto GBA	A and B and HHH MAC	11401 - MAC A	J - M	West Virginia
Palmetto GBA	A and B and HHH MAC	11402 - MAC B	J - M	West Virginia
Palmetto GBA	A and B and HHH MAC	11501 - MAC A	J - M	North Carolina
Palmetto GBA	A and B and HHH MAC	11502 - MAC B	J - M	North Carolina

Article Information

General Information

Article ID
A58527

Article Title
Billing and Coding: Complex Drug Administration Coding

Article Type
Billing and Coding

Original Effective Date
11/26/2020

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

CPT codes, descriptions and other data only are copyright 2022 American Medical Association. All Rights Reserved. Applicable FARS/HHSARS apply.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Current Dental Terminology © 2022 American Dental Association. All rights reserved.

Copyright © 2023, the American Hospital Association, Chicago, Illinois.

"SAD" Exclusion List

- Multi-year effort by CSRO to address discriminatory "SAD" exclusion list criteria
  - Multiple meetings with Contractor Medical Directors (CMDs) and CMS staff and leadership, independently and as part of the CSRO-led multi-provider coalition
- MACs continue to update articles with additional medications, but unclear how they complying with CMS' criteria in the program manual
  - "By the patient"
  - "Usually"
- Following CSRO advocacy, CMS issued a Request for Information (RFI) on this issue; CSRO and the coalition will submit formal response

Article - Self-Administered Drug Exclusion List: (SAD List) (A52800)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Future Effective
To see the currently-in-effect version of this document, go to the Public Versions section.

Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
Wisconsin Physicians Service Insurance Corporation	MAC - Part A	05101 - MAC A	J - 05	Iowa
Wisconsin Physicians Service Insurance Corporation	MAC - Part B	05102 - MAC B	J - 05	Iowa
Wisconsin Physicians Service Insurance Corporation	MAC - Part A	05201 - MAC A	J - 05	Kansas
Wisconsin Physicians Service Insurance Corporation	MAC - Part B	05202 - MAC B	J - 05	Kansas
Wisconsin Physicians Service Insurance Corporation	MAC - Part A	05301 - MAC A	J - 05	Missouri - Entire State
Wisconsin Physicians Service Insurance Corporation	MAC - Part B	05302 - MAC B	J - 05	Missouri - Entire State
Wisconsin Physicians Service Insurance Corporation	MAC - Part A	05401 - MAC A	J - 05	Nebraska
Wisconsin Physicians Service Insurance Corporation	MAC - Part B	05402 - MAC B	J - 05	Nebraska
Wisconsin Physicians Service Insurance Corporation	MAC - Part A	05901 - MAC A	J - 05	Alabama Alaska Arizona Arkansas California - Entire State Colorado Connecticut Delaware Florida Georgia Hawaii Idaho Illinois Indiana Iowa

CSRO

CELEBRATING 20 YEARS

Questions?

WEBSITE
www.csro.info

EMAIL
info@csro.info

PHONE
414.918.9825