

CY 24 Medicare Physician Fee Schedule: Academy Summary

On July 13, 2023, the Centers for Medicare & Medicaid Services (CMS) issued its proposed 2024 Physician Fee Schedule rule that announces and solicits public comments on proposed policy changes for the Medicare Part B program effective on or after January 1, 2024. These rules establish payment rates under Medicare Part B, other Medicare Part B payment policies (e.g., changes to the Medicare Diabetes Prevention Program), and proposed changes to the Medicare Quality Payment Program. Every year, the Academy of Nutrition and Dietetics submits comments to CMS on any proposed annual changes that impact registered dietitian nutritionists who are Medicare providers.

The Academy is requesting your input to the key pieces of the proposed rule listed below. Your input will help inform the Academy's written comments that will be submitted to CMS. It is not necessary for you to comment on every item listed in the summary; We ask that you provide comment on the items that are most relevant to your expertise.

Thank you for your time, expertise, and assistance in providing feedback. We are requesting feedback be sent to cleon@eatright.org by Wednesday, August 16th

Section II. D Payment for Telehealth Services under 1834 (m)

1. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

b. Requests to Add Services to the Medicare Telehealth Services List for CY 2024

(6) Health and Well-being Coaching

Topline: CMS is proposing to add Health and well-being coaching services to the Medicare Telehealth Services Lists on a temporary basis for CY 2024.

Summary: Received request to add CPT 0591T-0593T permanently, the evidence included in the submitter's request notes that these codes are similar to others already available on the Medicare Telehealth Services List. Based on the information submitted during the request (which contained two published meta analyses of literature on the clinical topic and an additional pre-publication meta-analysis that focuses on outcomes and benefits of the delivery of virtual health and wellbeing coaching), CMS has remaining concerns as to whether or not Medicare beneficiaries would receive meaningful clinical benefit from receiving virtual-only health and well-being coaching.

Note: Health and Well-being coaching (0591T-0593T) is a distinct services from MNT and Currently, is not a covered by Medicare for in-person care (private payers may). The definition of the term "Health Coach" can vary. The Academy's definition of terms states that a Certified Health Coach guides clients to achieve their health goals through lifestyle and behavior choices aligned with their long-term goals and values. There is no national credential organization for certification of Health Coaches therefore programs can look different in terms of course content, substance, delivery, and length. All Certified Health Coaches are considered Health Coaches, but not all Health Coaches are Certified Health Coaches. The National Board Certified Health & Wellness certification does have specific education requirements including an approved training program, skills assessment, work experience and continuing education requirements.

Comments/Response:

Do you support the addition of Health and Well Being Coaches to the Medicare approved services telehealth list on a temporary basis? Why or Why not?

(7) CMS Proposal to Add New Codes to the List

Topline: CMS is proposing to add new HCPCS Code GXXX5 (administration of a standardized evidence-based Social Determinants of Health Risk Assessment tool, 5-15 minutes) to the Medicare Telehealth Services List on a permanent basis.

Summary: For CY 2024, we are proposing coding and payment for social determinants of health risk assessments to recognize when practitioners spend time and resources assessing SDOH that may be impacting their ability to treat the patient. This service must be furnished by the practitioner on the same date they furnish an Evaluation and Management (E/M) visit, as the SDOH assessment would be reasonable and necessary when used to inform the patient's diagnosis and treatment plan established during the visit.

Additionally, we are proposing to add the SDOH risk assessment to the annual wellness visit as an optional, additional element with an additional payment. Separately, we are also proposing codes and payment for SDOH risk assessments furnished on the same day as an evaluation and management visit.

Comments/Response:

Do you support the addition of Social Determinants of Health Risk Assessment as part of the Annual Wellness visit to Medicare approved services telehealth list? Why or Why not?

e. Implementation of Provisions of the CAA, 2023

Summary: CMS is implementing the telehealth flexibilities that were included in the Consolidated Appropriations Act 2023 (CAA) by waiving the geographic and originating site requirements for Medicare telehealth services through the end of CY 2024. By doing so, patients all across the country will retain the ability to access telehealth services, particularly from their own homes. Per the CAA, CMS is extending payment for the CPT codes for audio-only telephone visits as well as all other services that were on the 2022 Medicare Telehealth Services List through 2024 and is delaying in-person visit requirements for telehealth mental health services.

For 2024, CMS is proposing to:

- 1) continue paying for telehealth services provided to patients in their homes at the non-facility payment rate, which is the same rate as in-person office visits;
- 2) allow direct supervision to be provided virtually.

(3) Originating Site Requirements

Topline: Maintain temporary expansion of the scope of telehealth originating sites for services furnished via telehealth to include any site in the United States where the beneficiary is located at the time of the telehealth service.

Comments/Response:*(5) Audio-Only Services*

Topline: Maintain temporary flexibility that CMS will continue to provide both coverage and payment for audio-only telehealth.

Comments/Response:

e. Place of Service for Medicare Telehealth Services

Topline: Beginning in CY 2024, we are proposing telehealth services furnished to people in their homes be paid at the non-facility PFS rate to protect access to mental health and other telehealth services by aligning with telehealth-related flexibilities that were extended via the CAA, 2023.

Summary: CMS is proposing that, beginning in CY 2024, claims billed with POS 10 (Telehealth Provided in Patient's Home) be paid at the non-facility PFS rate. When considering certain practice situations (such as in behavioral health settings, where practitioners have been seeing greater numbers of patients via telehealth), practitioners will typically need to maintain both an in-person practice setting and a robust telehealth setting. We expect that these practitioners will be functionally maintaining all of their PEs, while furnishing services via telehealth.

Claims billed with POS 02 (Telehealth Provided Other than in Patient's Home) will continue to be paid at the PFS facility rate beginning on January 1, 2024, as we believe those services will be furnished in originating sites that were typical prior to the PHE for COVID-19. In this way, we believe we would be protecting access to mental health and other telehealth services by aligning with telehealth-related flexibilities that were extended via the CAA, 2023; given shifting practice models, we will be more accurately recognizing the resource costs of behavioral health providers, .

Comments/Response:

2. Other Non-Face-to-Face Services Involving Communications Technology under the PFS

a. Direct Supervision via Use of Two-way Audio/Video Communications Technology

Topline: CMS is proposing to continue to 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.

Summary:

CMS is soliciting comment on:

1. Should CMS consider extending the definition of direct supervision to permit virtual presence beyond December 31, 2024?
2. Specifically, CMS is interested in input on:
 - a. Potential patient safety or quality concerns when direct supervision occurs virtually; for instance, if virtual direct supervision of certain types of services is more or less likely to present patient safety concerns
 - b. Is this flexibility more appropriate for certain types of services, or when certain types of auxiliary personnel are performing the supervised service?
 - c. Are there potential program integrity concerns such as overutilization or fraud and abuse that interested parties may have in regard to this policy?

Comments/Response:

b. Clarifications for Remote Monitoring Services

Topline: CMS is clarifying payment for these services, specifically the use in conjunction with other services (e.g. Chronic Care Management/Transitional Care Management /Behavioral Health Integration), data collection minimum, and clarifying that general supervision applies.

Summary: CMS outlines the post-COVID-19 public health emergency (PHE) Medicare payment policies for the CPT codes for Remote Physiologic Monitoring and Remote Therapeutic Monitoring, noting that these services can only be provided to established patients, that the codes describing monthly monitoring can be reported only if a minimum 16 days of data have been collected, and that the services may be reported for months when care management or surgical global services are also being reported. CMS also stated that these codes should be reported only once during a 30-day period, regardless if multiple medical devices are provided to a patient, and that they cannot be billed by more than one physician or other health professional in a month.

Note: In last year's proposed rule, RTM was limited to respiratory and musculoskeletal conditions and required the utilization of an FDA approved device.

Comments/Response:

c. Telephone Evaluation and Management Services

Topline: CMS is proposing to continue providing payment for CPT codes 98966-98968 for CY 24 by qualified non-physician healthcare professional through December 31, 2024.

Summary: In the March 31 COVID-19 IFC (85 FR 19264 through 19265), CMS finalized separate payment for CPT codes 99441 through 99443 and 98966 through 98968, which describe E/M and assessment and management services furnished via telephone. CPT codes 99441 through 99443 are telehealth services and will remain actively priced through 2024.

However, CPT codes 98966 – 98968 describe telephone assessment and management services provided by a qualified non-physician healthcare professional, and they are not telehealth services. We are proposing to continue to assign an active payment status to CPT codes 98966 through 98968 for CY 2024 to align with telehealth-related flexibilities that were extended via the CAA, 2023, specifically section 4113(e), which permits the provision of telehealth services through audio-only telecommunications through the end of 2024.

Comments/Response:

4. Payment for Outpatient Therapy Services, Diabetes Self-Management Training, and Medical Nutrition Therapy when Furnished by Institutional Staff to Beneficiaries in Their Homes Through Communication Technology

a. Background on Outpatient Therapy Services, Diabetes Self-Management Training and Medical Nutrition Therapy (furnished remotely by institutional staff)

Summary: During the PHE for COVID-19, outpatient therapy services, DSMT, and MNT could be furnished via a telecommunications system to beneficiaries in their homes, and bills for these services were submitted and paid either separately or as part of a bundled payment, when either personally provided by the billing practitioner or provided by

institutional staff and billed for by institutions (e.g., such as HOPDs, Skilled Nursing Facilities, and Home Health Agencies).

For professionals, CMS used waiver authority to expand the range of practitioners that can serve as distant site practitioners for Medicare telehealth services as described in section 1834(m)(4)(E) of the Act and §410.78 (b)(2), as well as to waive the originating site requirements for Medicare telehealth services described in section 1834(m)(4)(C) of the act. This allowed for outpatient therapy services to be furnished and billed by therapists in private practice, as well as for outpatient therapy services, DSMT, and MNT to be furnished via Medicare telehealth to beneficiaries in urban, as well as rural, areas, including to beneficiaries located in their homes. The Hospital Without Wall (HWW) waiver allowed hospitals to bill two different kinds of fees for services furnished remotely to patients in their homes:

1. Hospital facility payment in association with professional services billed under the PFS; and
2. Single payment for a limited number of practitioner services, when statute or other applicable rules only allow the hospital to bill for services personally provided by their staff.

These services are either billed by hospitals or by professionals, there would not be separate facility and professional billing. This latter category includes outpatient therapy services, DSMT, and MNT. In developing post-PHE guidance, CMS initially took the position that institutions billing for services furnished remotely by their employed practitioners (where the practitioners do not bill for their own services), would end with the PHE for COVID-19 along with the HWW waivers.

Note: MNT and DSMT do not fall under the “outpatient therapy services” benefit category. MNT can be billed as a hospital outpatient services on a UB04 form to Medicare Part A MAC and paid under Part B when the RDN enrolls as a Medicare provider and reassigns benefits to the hospital.

b. Proposal to Extend Billing Flexibilities for Certain Remotely Furnished Services Through the End of CY 2024 and Comment Solicitation

Topline: CMS is proposing to continue to allow institutional providers to bill for these services (i.e. MNT and DSMT) when furnished remotely in the same manner they have during the PHE for COVID-19 through the end of CY 2024.

Summary: CMS has stated that after reviewing input from interested parties, as well as relevant guidance, including applicable billing instructions, CMS is seeking comment on:

1. Current practice for these (e.g. MNT and DSMT) services when billed from a hospital outpatient department, including how and to what degree they continue to be provided remotely to beneficiaries in their homes.
2. Considering if certain institutions, as the furnishing providers, can bill for certain remotely furnished services personally performed by employed practitioners.

Comments/Response:

Section II.E Valuation of Specific Codes

(26) Payment for Caregiver Training Services (p218)

Topline: CMS is proposing to pay for CTS services when furnished by a physician or a non-physician practitioner (nurse practitioners, clinical nurse specialists, certified nurse-midwives, physician assistants, and clinical psychologists) or therapist (physical therapist, occupational therapist, or speech language pathologist) under an individualized treatment plan or therapy plan of care.

Summary: For CY 2024, CMS is proposing to pay for certain caregiver training services (CTS) in specified circumstances, so that practitioners are appropriately paid for engaging with caregivers to support people with

Medicare in carrying out their treatment plans. CMS is proposing to pay for these services when furnished by a physician or a non-physician practitioner (nurse practitioners, clinical nurse specialists, certified nurse-midwives, physician assistants, and clinical psychologists) or therapist (physical therapist, occupational therapist, or speech language pathologist) under an individualized treatment plan or therapy plan of care.

Defined Caregiver: CMS has broadly defined as a layperson (family member, friend, or neighbor, or guardian for those who are not legally dependent).

Patients Who Benefit from Care Involving Caregivers: CMS states that a patient-centered treatment plan should appropriately account for clinical circumstances where the treating practitioner believes the involvement of a caregiver is necessary to ensure a successful outcome for the patient and where, as appropriate, the patient agrees to caregiver involvement. Conditions include but are not limited to, stroke, traumatic brain injury (TBI), various forms of dementia, autism spectrum disorders, individuals with other intellectual or cognitive disabilities, physical mobility limitations, or necessary use of assisted devices or mobility aids.

Assign Active Payment Status for CPT codes 96202 and 96203 (caregiver behavior management/modification training services) and CPT codes 9X015, 9X016, and 9X017 (caregiver training services under a therapy plan of care established by a PT, OT, SLP). These codes allow treating practitioners to report the training furnished to a caregiver, in tandem with the diagnostic and treatment services furnished directly to the patient, in strategies and specific activities to assist the patient to carry out the treatment plan. Treating practitioners may train caregivers in a group setting with other caregivers who are involved in care for patients with similar needs for assistance to carry out a treatment plan.

CMS is seeking public comment:

1. What does coverage look like in states that typically cover services similar to CTS under their Medicaid programs? Would such coverage be duplicative of the CTS service codes?
2. Are there instances where payment for is currently available for CTS through other federal or other programs?
3. Their definition of ‘caregiver’ for purposes of CTS and is also interested if there are any additional elements of a caregiver that we should consider incorporating in this proposed CTS caregiver definition.
4. How do clinician and caregiver interactions would typically occur, including when the practitioner is dealing with multiple caregivers and how often these services would be billed considering the established treatment plan involving caregivers for the typical?
 - a. How might RDNs utilize this service?

Note: The Academy was involved in the creation and valuation of these codes and in last year’s final rule CMS did not recognize them for payment under the PFS.

Comments/Response:

RDNs were not listed as eligible providers for CTS. Do you support advocating for RDNs to be allowed to deliver CTS? Why or why not? Please provide examples that demonstrate your rationale.

(27) Services Addressing Health-Related Social Needs (Community Health Integration services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation services) (p231)

b. Community Health Integration (CHI) Services

Topline: For CY 2024, CMS is proposing coding and payment changes to better account for resources involved in furnishing patient-centered care involving a multidisciplinary team of clinical staff and other auxiliary personnel

Summary: Specifically, CMS is proposing to pay separately for Community Health Integration, Social Determinants of Health (SDOH) Risk Assessment, and Principal Illness Navigation services to account for resources when clinicians involve community health workers, care navigators, and peer support specialists in furnishing medically necessary care. While care support staff have been able to serve as auxiliary personnel to perform covered services incident to the services of a Medicare-enrolled billing physician or practitioner, the services described by the proposed codes are the first that are specifically designed to describe services involving community health workers, care navigators, and peer support specialists.

CMS is proposing to create two new G codes describing CHI services performed by certified or trained auxiliary personnel, which may include a CHW, incident to the professional services and under the general supervision of the billing practitioner. CHI services could be furnished monthly, as medically necessary, following an initiating E/M visit (CHI initiating visit) in which the practitioner identifies the presence of SDOH need(s) that significantly limit the practitioner's ability to diagnose or treat the problem(s) addressed in the visit.

- The CHI initiating visit would be an Evaluation/Management (E/M) visit (other than a low-level E/M visit that can be performed by clinical staff) performed by the billing practitioner who will also be furnishing the CHI services during the subsequent calendar month(s) and would be a pre-requisite to billing for CHI services.
- The subsequent CHI services would be performed by a CHW or other auxiliary personnel incident to the professional services of the practitioner who bills the CHI initiating visit.

CMS is proposing to designate CHI services as care management services that may be furnished under the general supervision of the billing practitioner. Lastly, while we are proposing to allow CHI services to be performed by auxiliary personnel under a contract with a third party, there must be sufficient clinical integration between the third party and the billing practitioner in order for the services to be fully provided, and the connection between the patient, auxiliary personnel, and the billing practitioner must be maintained.

CMS is seeking comment:

1. Should any professional services other than an E/M visit performed by the billing practitioner be considered as the prerequisite initiating visit for CHI services, including, for example, an annual wellness visit (AWV) that may or may not include the optional SDOH risk assessment also proposed in this rule.
 - a. *Note:* Under section 1861 of the Social Security Act the AWV can be furnished by a physician or practitioner, or by other types of health professionals, including RDNs whose scope of practice does not include the diagnosis and treatment involved in E/M services, for example a health educator.
2. Typical amount of time practitioners spend per month furnishing CHI services to address SDOH needs that pose barriers to diagnosis and treatment of problem(s) addressed in an E/M visit.
3. Typical duration of CHI services, in terms of the number of months for which practitioners furnish the services.
4. Where and how these services would be typically provided (e.g., in-person, audio-video, two-way audio).
5. Whether a billing practitioner may arrange to have CHI services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs, if all of the "incident to" and other requirements and conditions for payment of CHI services are met.

Comments/Response:

Note: Additional question for consideration:

1. Do you account for their services under chronic care management (CCM) codes?
2. Are you employed by the same entity that employs physicians?
3. Do physicians provide direct supervision for their interactions with patients (e.g., immediately available in the same location)?
4. How do payments between health care provider organizations, and community-based organizations, local governments, and social service organizations account for the costs of services provided by CHWs?
5. Do CHWs provide services in association with any Medicare preventive services?
6. Does your state have any laws in place regulating CHWs? If so, please share.

d. Social Determinants of Health (SDOH) –Proposal to establish a stand-alone G code

ii. Proposed SDOH Risk Assessment Code

Topline: CMS is proposing the development and payment for new HCPCS code that can be used when assessing for SDOH. This is tied to an E/M visit.

Summary: The taking of a social history is generally performed by physicians and practitioners in support of patient-centered care to better understand and help address relevant problems that are impacting medically necessary care. We believe the resources involved in these activities are not appropriately reflected in current coding and payment policies. As such, we are proposing to establish a code to separately identify and value a SDOH risk assessment that is furnished in conjunction with an E/M visit. We are proposing a new stand-alone G code, GXXX5, administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every six months.

Comments/Response:

Note: RDNs are not eligible providers for E/M Visits. However, should the option be available to RDNs? Would you support this proposal?

Section II.I Supervision of Outpatient Therapy Services, KX Modifier Thresholds, Diabetes Self-Management Training (DSMT) Services by Registered Dietitians and Nutrition Professionals, and DSMT Telehealth Services (p316)

3. Diabetes Self-Management Training (DSMT) Services Furnished by Registered Dietitians (RDs) and Nutrition Professionals

Topline: CMS is proposing to correct/update regulatory language that allows for RDNs to submit claims as the sponsor of DSMT programs.

Summary: During the CY 2022 PFS rulemaking, we adopted a regulation at § 410.72(d) that requires the services that RDs and nutrition professionals furnish to beneficiaries to be directly performed by them. This is based on the MNT regulations at subpart G, §§ 410.130 – 410.134. When developing this policy, we were only referring to MNT services. These MNT services are distinct from the DSMT services that RDs or nutrition professionals may furnish when they are or represent an accredited DSMT entity. We note that the RD or nutrition professional, when named in or a sponsor of an accredited DSMT entity, may act as the DSMT certified provider, which is defined at section 1861(qq) of the Act as a physician, or other individual or entity to which Medicare makes payment for other services.

This spring, the Academy, Association of Diabetes Care & Education Specialists, and the American Diabetes Association met with CMS regarding the need to clarify language in the federal register. The previous language had been interpreted by some programs as questioning the RDN's ability to act as the certified program provider for DSMT programs. This item in the proposed rule seeks to clarify that RDN or other qualified nutrition professional is eligible to bill on behalf of an entire DSMT program or entity.

Comments/Response:

4. DSMT Telehealth Issues

(a) Distant Site Practitioners

Topline: CMS is proposing to align regulations by stating RDNs may still act as the certified provider for the DSMT program/entity when part of a DSMT programs that are delivered via telehealth.

Summary: CMS is proposing to clarify that when RDNs enrolled in Medicare intend to bill for the DSMT service, RDNs can provide DSMT services and submit claims as the "certified provider" on behalf of the DSMT Program/entity.

CMS acknowledged that RDNs in the group or team of professionals (along with RNs and/or pharmacists) that are performing DSMT services in addition to the sponsoring or billing RD or nutrition professional are functioning as the certified provider. Since CMS allows RDNs and other DSMT certified providers to bill on behalf of the DSMT entity when other professionals personally furnish the service in face-to face encounters, they are clarifying regulatory language to reflect the same when DSMT is furnished as a Medicare telehealth service.

To increase access to DSMT telehealth services, we are proposing to codify billing rules for DSMT services furnished as Medicare telehealth services per the Social Security Act to allow distant site practitioners who can appropriately report DSMT services furnished in person by the DSMT entity, such as RDNs and nutrition professionals, physicians, nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs), to also report DSMT services furnished via telehealth by the DSMT entity, including when the services are performed by others as part of the DSMT entity.

(b) Telehealth Injection Training for Insulin-Dependent Beneficiaries

Topline: CMS is proposing to allow injection training to be delivered via telehealth.

Summary: The Current Medicare Claims processing manual requires that 1 hour of the 10-hour DSMT benefit's initial training and 1 hour of the 2-hour follow-up annual training to be furnished in-person to allow for effective injection training when injection training is applicable for insulin-dependent beneficiaries. CMS is proposing to allow the 1- hour of in-person training (for initial and/or follow-up training), when a required for insulin-dependent beneficiaries, to be delivered via telehealth.

Comments/Response:

Section III.B. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

2. Implementation of the Consolidated Appropriations Act (CAA), 2023

a. Section 4113 of the Consolidated Appropriations Act, 2023

Topline: Maintain payment for telehealth flexibilities CMS put into place for both FQHC and RHC.

Summary: The CAA, 2023 (Pub. L. 117-328, December 29, 2022) extends the Medicare telehealth flexibilities enacted in the CAA, 2022 for a period beginning on the first day after the end of the PHE for COVID-19 and ending on December 31, 2024, if the PHE ends prior to that date.

Specifically related to RHCs and FQHCs, the CAA, 2023 amends section 1834(m)(8) of the Act to extend payment for telehealth services furnished by FQHCs and RHCs for the period beginning on the first day after the end of the COVID-19 PHE and ending on December 31, 2024. Payment continues to be made under the methodology established for telehealth services furnished by FQHCs and RHCs during the PHE, which is based on payment rates that are similar to the national average payment rates for comparable telehealth services under the PFS. We believe that extending this definition of direct supervision for RHCs and FQHCs through December 31, 2024, would align the timeframe of this policy with many of the previously discussed PHE-related telehealth policies that were extended under provisions of the CAA, 2023.

Comments/Response:

b. Direct Supervision via Use of Two-way Audio/Video Communications Technology

Topline: For RHCs and FQHCs, we are proposing to continue to define “immediate availability” as including real-time audio and visual interactive telecommunications through December 31, 2024.

Summary: Similar to physician services paid under the PFS, outside the circumstances of the PHE, direct supervision of RHC and FQHC services does not require the physician to be present in the same room. However, the physician must be in the RHC or FQHC and immediately available to provide assistance and direction throughout the time the incident to service or supply is being furnished to a beneficiary.

For RHCs and FQHCs, we are proposing to continue to define “immediate availability” as including real-time audio and visual interactive telecommunications through December 31, 2024. Therefore, we are soliciting comment on whether we should consider extending the definition of direct supervision to permit virtual presence beyond December 31, 2024. When compared to professionals paid under the PFS, RHCs and FQHCs have a different model of care and payment structure. Therefore, we seek comment from interested parties on potential patient safety or quality concerns when direct supervision occurs virtually in RHCs and FQHCs

Comments/Response:

c. Services Addressing Health-Related Social Needs: Community Health Integration Services and Principal Illness Navigation Services

In this effort to improve payment accuracy for care coordination in RHCs and FQHCs, we are exploring ways to better identify the resources for helping patients with serious illnesses navigate the healthcare system or removing health-related social barriers that are interfering with their ability to execute a medically necessary plan of care. Examples include helping patients understand and implement the plan of care, and locate and reach the right practitioners and providers to access recommended treatments and diagnostic services, considering the personal circumstances of each patient.

Payment for these activities, to the extent they are reasonable and necessary for the diagnosis and treatment of the patient’s illness or injury, is currently included in the RHC AIR or under the FQHC PPS payment amount for visits and some care management services. Medical practice has evolved to increasingly recognize the importance of these activities, and we believe RHCs and FQHCs are performing them more often. However, this work is not explicitly identified in current coding. Accordingly, we are proposing to create new coding to expressly identify and value these

underutilized and undervalued services for PFS payment, and distinguish them from current care management services. We are considering the new coding for purposes of payment to RHCs and FQHCs.

(2) Payment for Community Health Integration (CHI) Services in RHCs and FQHCs

Topline: Proposal to add two new HCPCS codes that describe CHI services performed by certified or trained auxiliary personnel which may include a Community Health Worker, incident to the professional services and under the general supervision of the billing provider.

Summary: Similar background and rationale to section III.B.4.a

Comments/Response:

Section III.I Medicare Diabetes Prevention Program (MDPP) (p771)

1. Proposed Changes to § 410.79 by amending paragraphs (b), (c)(2)(i) and (e)(2)

Topline: Regarding the MDPP, CMS is proposing to extend several COVID-19 PHE flexibilities an additional four years, including alternatives for in-person weight measurements and eliminating the cap on the number of services that may be provided virtually (though suppliers must continue to maintain in-person recognition). Additionally, CMS is proposing to allow up to 22 sessions during the 12-month core services period, convert to a hybrid fee-for-service and weight loss payment structure, align recognition with CDC's Diabetes Prevention Recognition Program, and make several definitional changes for added clarity.

Summary: CMS proposes an update to the payment structure for MDPP programs from a performance-based attendance and weight loss structure to a hybrid structure that pays for attendance on a fee-for-service basis and diabetes risk reduction (that is, weight loss), on a performance basis.

- Proposing fee for- service payments for beneficiary attendance, allowing for up to 22 attendance-based payments versus the five that are currently in place allowing beneficiaries to attend a maximum of 22 sessions during the core services period, including up to 16 sessions in months 1-6 and up to 6 sessions in months 7-12.
- Update the performance goal to mean a weight loss goal that an MDPP beneficiary must achieve during the MDPP services period for an MDPP supplier to be paid a performance payment, and removing the performance-based payments for attendance from the performance goal. CMS will retain the diabetes risk-reduction performance payments, which include payments for 5% and 9% weight loss
 - Proposing an HCPCS G code- "Maintenance of 5 percent weight loss from baseline, months 7-12, this will replace current HCPCS G-codes G9878 and G9879"

TABLE 41: Proposed Changes to MDPP Payment Structure to include Attendance-Based Service Payments and Diabetes Risk Reduction Performance Payments

HCPSC G-Code	Payment Description*	CY 2024
GXXX0	Behavioral counseling for diabetes prevention, in-person, group, 60 minutes	\$25
GXXX1	Behavioral counseling for diabetes prevention, distance learning, 60 minutes	\$25
G9880	5 percent WL Achieved from baseline weight	\$145
GXXX2**	Maintenance 5 percent WL from baseline in months 7-12	\$8
G9881	9 percent WL Achieved from baseline weight	\$25
G9890	Bridge Payment	\$25
Subtotal Maximum Attendance-Based Payment		\$550
Total Maximum Payment		\$768

*Medicare pays up to 22 sessions billed with codes GXXX1 and GXXX0, combined, in a 12-month period:

Months 1-6: 1 in-person or distance learning session every week (max 16 sessions)

Months 7-12: 1 in-person or distance learning session every month (max 6 sessions)

**Suppliers must submit claim for 5 percent weight loss (G9880) prior to submitting claims for the maintenance 5 percent WL from baseline in months 7-12.

TABLE 42: CY 2023 MDPP Payment Structure

HCPSC G-Code	Payment Description	CY 2023
Core Sessions (Months 1-6)		
G9873	Attend 1 Core Session	\$38
G9874	Attend 4 Core Sessions	\$115
G9875	Attend 9 Core Sessions	\$191
Core Maintenance (CM) Sessions (Months 7-12)		
G9876	Attend 2 Core Maintenance Sessions (No 5% WL) in CM Interval 1 (Months 7-9)	\$76
G9877	Attend 2 Core Maintenance Sessions (No 5 percent WL) in CM Interval 2 (Months 10-12)	\$76
G9878	Attend 2 Core Maintenance Sessions (5 percent WL) in CM Interval 1 (Months 7-9)	\$101
G9879	Attend 2 Core Maintenance Sessions (5 percent WL) in CM Interval 2 (Months 10-12)	\$101
G9880	5 percent WL Achieved from baseline weight	\$184
G9881	9 percent WL Achieved from baseline weight	\$38
G9890	Bridge Payment	\$38
G9891	Non-payable session code (This code is for reporting purposes only).	\$0
Core Maintenance Sessions (Months 7-12)**		
G9882	Attend 2 Ongoing Maintenance (OM) Sessions in OM Interval 1 (Months 13-15)	\$57
G9883	Attend 2 Ongoing Maintenance Sessions in OM Interval 2 (Months 16-18)	\$57
G9884	Attend 2 Ongoing Maintenance Sessions in OM Interval 3 (Months 19-21)	\$58
G9885	Attend 2 Ongoing Maintenance Sessions in OM Interval 4 (Months 22-24)	\$58
Subtotal Maximum Attendance-Based Payment		\$496
Total Maximum Payment		\$768

**In the CY 2022 PFS, CMS removed the Ongoing Maintenance Sessions for those beneficiaries who started MDPP services on or after January 1, 2022. MDPP beneficiaries who were participating in the Set of MDPP Services on or before December 31, 2021 may continue with the ongoing maintenance phase if they maintain 5 percent weight loss and attendance requirements.

Extend PHE- related flexibilities for four years (through December 31, 2027). MDPP regulations provide for the following flexibilities during the PHE or an applicable 1135 waiver event, and will apply only to MDPP suppliers that have and maintained CDC DPRP in-person recognition:

- *Alternatives to the requirement for in-person weight measurement*
- *Elimination of the maximum number of virtual services*
- *MDPP suppliers may provide virtual services as long as they are provided in a manner consistent with the CDC DPRP standards for distance learning*

Suppliers may offer a combination delivery of MDPP, including both in-person and distance learning.

- Distance learning must be delivered only in a synchronous virtual manner through telephonic or video conference.
- Proposing the creation of a new HCPSC G-code specific to “distance learning,” This will be in place of the virtual modifier.

Comments/Response:**Section III.L. Expand Diabetes Screening and Diabetes Definitions (p859)**

Topline: Provides coverage for A1c testing for screening and removed codified diagnostic test from MNT and DSMT benefits

Summary: CMS is proposing to cover the hemoglobin A1C (HbA1c) test for diabetes and prediabetes screening purposes, as consistent with updated United States Preventive Services Task Force recommendations. The agency is also proposing to align screening frequency caps twice within a rolling 12-month period and simplify the definition of diabetes by removing codified clinical test requirements, which is required for some but not all diabetes services.

Comments/Response:**Section III.S A Social Determinants of Health Risk Assessment in the Annual Wellness Visit**

Topline: For CY 2024, CMS is proposing 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.

Summary: For CY 2024, CMS is proposing 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, CMS is proposing to add the SDOH risk assessment to the annual wellness visit as an optional, additional element with an additional payment.

Comments/Response:**CY 2024 PFS Rate setting and Conversion Factor**

Reduction in Medicare Conversion Factor (CF): The proposed rule predicts a 3.36% reduction in the 2024 Medicare conversion factor, lowering it from \$33.8872 to \$32.7476.

- The proposed CY 2024 PFS conversion factor (CF) is \$32.75, a decrease of \$1.14 from CY 2023.
- This CF accounts for the statutorily required update to the CF for CY 2024 of 0%, the 1.25% increase in PFS payments for CY 2024 as required by the Consolidated Appropriations Act, 2023, and the statutorily required budget neutrality adjustment of -2.17% to account for changes in Relative Value Units.
- Unfortunately, these cuts coincide with ongoing growth in the cost to practice medicine as CMS projects a 4.5% Medicare Economic Index (MEI) increase for 2024.
- Estimated Combined Impact for RDNs of the proposals in the Notice of Proposed Rulemaking (NPRM) and Reduction of the Temporary Conversion Factor increase from 2.5% to 1.25% is -3.30%