Medicare Physician Payment Scenarios for 2024

Background

Congress passed a two-tiered continuing resolution (CR) that extended only a handful of healthcare programs into early 2024 and left unresolved many critical payment issues, including the Medicare physician fee schedule (PFS) conversion factor (CF) cut and bonuses for advanced alternative payment models (APMs). Given the uncertainty of congressional action, many questions remain regarding whether Medicare payment will be delayed or retroactively adjusted, and about the administrative burden that could be involved if there are delays past the start of 2024.

Without any further action by Congress, PFS rates will decline for services provided on or after January 1, 2024, by 3.37% compared to 2023 rates, while rates for anesthesia services will decline by 3.27% compared to 2023. There will also be no bonus for participation in APMs for the 2024 performance year unless legislation is passed.

The following questions and answers outline how Medicare PFS claims could be impacted based on past experience and steps the Centers for Medicare & Medicaid Services (CMS) might take to mitigate the impact on claims and payment. Final action will ultimately depend on Congress and CMS.

GENERAL QUESTIONS ABOUT PAYMENT DELAYS

Will the payment rates be reduced immediately for services furnished on or after January 1, 2024?

Medicare Administrative Contractors (MACs) are responsible for paying Medicare fee-for-service (FFS) claims, including claims for PFS services, according to the policies and rates set by CMS. While the lower CFs apply to all PFS services with dates of service on or after January 1, 2024, it is important to understand that MACs do not pay PFS claims immediately. By law, MACs wait a minimum of 14 days to pay electronic claims and 29 days to pay paper claims.[1] This statutory requirement offers some time for Congress to pass legislation within the first weeks of 2024 without any disruptions in payment.

If Congress does pass legislation early in January 2024 (perhaps even by January 19, 2024, the first deadline of the two-tiered CR), providers will receive higher payments in accordance with the relief provided by Congress and will not be paid at a rate that includes the full CF reduction (if the legislation includes a retrospective change to January 1, 2024). In any case, claims for services provided in 2023 will continue to be paid at 2023 fee schedule rates.

Past the two-week mark, if Congress still has not acted, it is less clear how CMS will move forward with Medicare PFS claims. When faced with a similar situation in the past, CMS instructed MACs to hold certain claims for payment and then start to release other claims for payment on a “rolling basis.” That way, if legislation called for retroactive payment adjustments, MACs would not have to reprocess every claim. For example, after passage of the Bipartisan Budget Act of 2018, CMS instructed MACs on January 25, 2018, to release for processing claims with dates of receipt from January 1 to 10, 2018, and hold others on a rolling basis.

[1] See Social Security Act Section 1842(c)(3).

If Congress retroactively provides a fix to the Medicare PFS CFs, CMS will provide detailed instructions to MACs on how to proceed. Historically, CMS has typically issued an announcement followed by a more formal Medicare Learning Network®(MLN) article providing additional details.

If Congress does not enact legislation instituting a fix to the Medicare PFS CF by January 1, 2024, do providers have to hold on to PFS claims with dates of service on or after January 1, 2024, or should they continue to submit them to MACs?

Providers do not have to hold on to claims with dates of service on or after January 1, 2024. They can continue to submit claims as they would normally do under their current billing practices. Any holds to these claims would be done by MACs at the instruction of CMS.

What if relief for the fee schedule is passed much later in 2024? Will claims be updated retroactively?

If Congress has not acted for several months, MACs will process claims with the published 2024 rates. If Congress subsequently enacts relief later in 2024, CMS may choose to instruct MACs to simply add an extra amount to Medicare claims for the remainder of 2024 to make physicians whole over the course of the year. This was the experience in past years and prevented the administrative burden of reprocessing claims.

What needs to happen operationally if Congress passes a patch to the fee schedule conversion factors?

If Congress passes relief for the PFS CFs as it has in years past, CMS will officially update the CFs and then revise the Medicare PFS payment files as necessary. The process of updating the CFs and all associated payment files can usually be completed within a few days of the legislation being passed into law. However, implementing the change in the claims processing system can take additional time.

How will a congressional fix to the Medicare PFS CFs affect Medicare Advantage health plan payments to providers?

There is no impact on Medicare Advantage (MA) payments to providers. The 2024 PFS CFs cuts and any legislative fix enacted by Congress technically only impacts Medicare FFS payments. MA plans negotiate payment rates with the providers in their networks independently, and CMS is prohibited by law from interfering with contract negotiations between health plans and providers. Section 1854(a)(6)(B)(iii) of the Social Security Act, commonly known as the “non-interference clause,” prohibits CMS from requiring a health plan to contract with a particular healthcare provider or to use a particular price structure for payment under such a contract.

Some MA plans (as well as commercial insurers) peg payments to Medicare rates. In these instances, changes to Medicare FFS payments may indirectly impact MA payment rates.

QUESTIONS ABOUT CLAIMS REPROCESSING

What are the Medicare claims reprocessing requirements?

Typically, MACs receive specific instructions from CMS on which claims to reprocess and the timeline for doing so. When claims are reprocessed, MACs pay providers the difference between what they were paid initially and the revised payment amount for each service.

If reprocessing occurs, do providers have to request that claims be reprocessed or adjusted?

Generally, no. In the majority of cases, providers will not have to request adjustments because the MACs will automatically reprocess claims. In the past, CMS has asked that providers not resubmit claims because they may be denied as duplicate claims and slow the retroactive adjustment process.

What is the timeframe for the claims to be reprocessed?

The timeframe will vary by claim type, claim volume and the individual MAC. In the past, when MACs have needed to reprocess a lot of claims, CMS has provided six months for MACs to complete the reprocessing.

Providers may contact their MACs about the estimated completion date.

QUESTIONS ABOUT THE ALTERNATIVE PAYMENT MODEL BONUS PAYMENT

How would congressional action affect the APM bonus payment?

As initially established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), providers who have a certain proportion of payments or patients tied to an Advanced APM are called qualifying APM participants (QPs) and are eligible for an incentive payment.[2] APM bonuses, including the bonus paid in 2024 and the bonus paid in 2025, should not be impacted by legislation.

APM Bonuses in 2024

Clinicians who were determined to be QPs during performance year 2022 will receive a 5% bonus in 2024. The bonus is based on the claims the provider submitted with dates of service from January 1, 2023, through December 31, 2023, and processing dates of January 1, 2023, through March 1, 2024, to allow 60 days for claims run-out.

Since the dates of service on which the bonus is based all occurred within CY 2023, the size of the bonus will not be affected by any legislation that impacts CY 2024 PFS payments.

APM Bonuses in 2025

Clinicians who were determined to be QPs during performance year 2023 will receive a 3.5% bonus in 2025. The bonus will be based on the claims the provider submits with dates of service from January 1, 2024, through December 31, 2024, and processing dates of January 1, 2024, through March 1, 2025, to allow 60 days for claims run-out.

Since CMS will conduct the bonus calculation in 2025 after a 60-day claims run-out period, the agency's calculation of the APM bonus will be based on the final payments providers received for PFS services delivered from January 1, 2024, through December 31, 2024. Thus, even if providers are initially paid for 2024 PFS services at the lower rate and receive higher payments later (either through reprocessing or by receiving add-on payments), the aggregate payment amount for covered professional services amounts on which the APM bonus is based should be accurate and take into account any adjustments made to PFS payments over the course of the year.

[2] The APM bonus of 5% under MACRA expires in payment year 2024. However, Congress extended the bonus at a lower amount of 3.5% for payment year 2025 in the Consolidated Appropriations Act, 2023.

APM Bonuses in 2026

There is currently no APM bonus for 2026 based on whether a clinician is determined to be a QP in performance year 2024. It important for both current and prospective APM participants, such as accountable care organizations (ACOs), to know early on in 2024 whether there will be a bonus in 2026 to help inform their decisions regarding whether to start or continue participating in these models. For this reason, many stakeholders are calling for an extension to the APM bonuses in early 2024.

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