ASCO Practice Impact Analysis of the Medicare Physician Fee Schedule Proposed Rule for Calendar Year 2024

August 9, 2023

Executive Summary

The Medicare Physician Fee Schedule (MPFS) proposed rule for calendar year (CY) 2024 was recently released by the Centers for Medicare & Medicaid Services.

Oncology practices are expected to receive the following decreases in reimbursement due to the MPFS proposed rule, to include changes in relative value units (RVUs) and a 3.4% decrease to the MPFS conversion factor:

- Hematology/Oncology: 0.2% decrease to Medicare allowable rates
- Radiation Oncology: 3.6% decrease to Medicare allowable rates
- Gynecologic Oncology: 0.7% decrease to Medicare allowable rates
- Surgical Oncology: 2.9% decrease to Medicare allowable rates

Differences among specialty-specific impacts is largely the result of increases in RVUs for outpatient cognitive services and labor-intensive services, countered by various budget neutrality mechanisms that decrease reimbursement for other expenses.

Conversion Factor (CF)—For 2024, the temporary increase to the CF of 2.5% is reversed and replaced with a one-year temporary increase of 1.25%. The 2024 proposed rule also includes a -2.17% budget neutrality adjustment necessitated by a new Evaluation and Management (E&M) code created by CMS. Overall, the 2024 CF will decrease by 3.4%.

Specialty Impact—CMS calculates that the specialty specific impact of proposed changes is a 2% increase for hematology/oncology and 2% decrease for radiation oncology. CMS' estimates, however, do not factor in the smaller temporary increase provided by the Consolidated Appropriations Act (CAA) for 2024 or the expiration of a temporary 1.0 floor for the physician work Geographic Practice Cost Index (GPCI). When included in the analysis, the cumulative effect is -1.8%.

Physician Work Valuation—In the CY 2021 MPFS final rule, CMS increased the valuation of office/outpatient visits and added a new add-on code, G2211 for complex visits. For 2021, CMS assumed that hematology/oncology would add G2211 to 90% of visits. These two factors resulted in in a -10% budget neutrality adjustment for 2021, significantly decreasing reimbursement for non-cognitive services. Through the CAA, Congress stopped CMS from paying for G2211 and provided a temporary increase in the CF to negate decreases due to the new work RVUs (wRVUs) for office/outpatient visits. The temporary hold on payment for G2211 expires at the end of 2023 and CMS is now predicting that G2211 will be added to 38% of all office/outpatient visits. Restrictions on use of the code include application only to

office/outpatient visits; the expectation that certain specialties will use the code only with new patient visits; and a prohibition on adding it to visits paired with a "minor procedure." Because CMS did not update global services to include the increase in wRVUs for office/outpatient visits or the addition of G2211, the result is drastic changes in total wRVUs per specialty. Since 2020, hematology/oncology has experienced a 22% increase in wRVUs for the same set of services, whereas radiation oncology has experienced only a 2% increase for their services. While a 22% increase in wRVUs for hematology/oncology may be expected to result in increased compensation for physicians, both independent and hospital-based practices must account for reductions in payment for other services and overall payments which fail to sufficiently meet increased labor, supply, and equipment costs. The result is that employers have decreased compensation per wRVU for many productivity-driven contracts.

Clinical Labor Expense—Medicare allowable rates are calculated from the combination of wRVUs, practice expense RVUs (peRVUs), and malpractice RVUs (mpRVUs), adjusted geographically—Medicare uses GPCIs to adjust RVUs for each locality—and through annual changes in the MPFS CF. Practice expense is further broken down into direct and indirect expenses, with clinical labor falling into the direct expense category.

In the 2022 MPFS final rule, CMS initiated a four-year phase-in to update the pricing for clinical labor rates. For most labor codes, rates per minute had not been updated for 20 years (i.e., since the 2002 MPFS final rule). As a result, direct practices expenses have been grossly undercalculated for many years. For 2024, CMS proposes to implement the third year of the clinical labor pricing update.

Embedded within the calculation of the peRVUs is a budget neutrality mechanism titled "direct scaling adjustment" which converts actual labor, supply, and equipment expenses to adjusted values. If specific direct practice expenses increase or decrease, contraposed changes to the direct scaling adjustment keep the total number of direct peRVUs equal to the prior year. The increases to labor expenses precipitated a decrease in the direct scaling adjustment; to pay for increases to direct labor, rates for all direct expenses have decreased by 22% and are expected to decrease further in 2025.

Impact on Specific Oncology Services—The addition of G2211, reductions in the direct scaling adjustment and MPFS CF, and loss of the 1.0 floor for the work GPCI, combine for changes in reimbursement unique to each category of services. Reimbursement for office/outpatient visits will decrease an average of 2% in 2024, except when adding G2211, which will increase total reimbursement for a visit between 7.3% to 69%, depending on the level of service.

Place of Service and State Specific Impact—Analysis of national datasets including all 53 Medicare states and territories shows that, within hematology/oncology, payments are expected to decrease 0.4% for services performed in the office setting and 4.0% in the inpatient hospital setting. For services performed in outpatient hospital settings, the professional component of payments is expected to increase. Within radiation oncology, payments are expected to decrease in all settings. At a state level, the loss of the 1.0 floor for the physician work GPCI

results in further disparities in reimbursement. When considering all oncology specialties, the impact to individual states ranges from -3.7% to -0.2%.

Please see the American Society of Clinical Oncology's (ASCO's) full analysis below for additional details.

Medicare Physician Fee Schedule

The following analysis explores the impact of the 2024 Medicare Physician Fee Schedule (MPFS) proposed rule on oncology specialties. Within the MPFS, the Centers for Medicare & Medicaid Services (CMS) establishes relative value units (RVUs) and allowable rates for independent physician practices and the professional component for hospital-based practices, excluding drugs and laboratory tests.

This analysis covers the following:

- Updates to the MPFS conversion factor
- Payment for G2211 for complex office/outpatient visits
- Implementation of the third year of the clinical labor pricing update
- Impacts on oncology specialties and services categories
- Impacts on specific service codes common to oncology
- State specific impacts owing to updated geographic adjustments and loss of the statutory 1.0 work floor.

Conversion Factor

The MPFS conversion factor (CF) is calculated for each year based upon statutory updates specified in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), as well as a budget neutrality adjustment required by law. These factors can increase or decrease the conversion factor depending on RVU updates and other changes subject to budget neutrality.

In 2021, the MPFS rule have included significant decreases in the CF because of statutory budget neutrality adjustments triggered by an increase in physician work relative value units (wRVUs) assigned to office and outpatient visits. To stave off large cuts during the COVID-19 pandemic, Congress passed a series of temporary increases:

- The Consolidated Appropriations Act of 2021 (CAA, 2021) provided a 3.75% increase for 2021
- The Protecting Medicare and American Farmers from Sequester Cuts Act provided a 3.0% increase for 2022
- The Consolidated Appropriations Act, 2023 (CAA, 2023) provided a 2.5% increase for 2023 and 1.25% increase for 2024

Rather than having a cumulative effect, these temporary increases are reversed when calculating subsequent years' MPFS CF, resulting in a declining value each year.

For 2024, the temporary increase of 2.5%, as provided by CAA, 2023, is replaced with a one-year temporary increase of 1.25%. The 2024 proposed rule also includes a -2.17% budget neutrality adjustment necessitated by a new Evaluation and Management (E&M) code for complex visits, created by CMS. Overall, the 2024 proposed MPFS would decrease the CF by 3.4% (Table 1).

Current Conversion Factor	33.8872
Conversion Factor without 2023 Temporary Increase under CAA, 2023 (2.5 Percent Increase for CY 2023)	33.0607
CY 2024 RVU Budget Neutrality Adjustment	-2.17%
2024 Temporary Increase under CCA, 2023	1.25%
Proposed 2024 Conversion Factor	32.7476

Table 1. Current and Proposed MPFS Conversion Factors

Specialty Impact

In Table 104 of the proposed rule, CMS calculated the specialty specific impact of proposed changes to be a 2% increase for hematology/oncology and 2% decrease for radiation oncology. However, Table 104 is not a complete representation of specialty impact. First, Table 104 does not reflect expiration of the 2.5% temporary increase for CY 2023 and its replacement with a 1.25% temporary increase in CY 2024. Second, Table 104 does not reflect the impact of an expiring temporary 1.0 floor for the physician work Geographic Practice Cost Index (GPCI) extended through CY 2023 by CCA, 2021. ASCO's analysis shows the cumulative effect of these two factors results in a -1.8% change, against not reflected in specialty estimates displayed in Table 104 of the proposed rule.

ASCO conducted a more complete analysis and determined the specialty-specific impacts (Figure 1) to be: hematology/oncology specialties (-0.2%), radiation oncology (-3.6%), surgical oncology (-2.9%) and gynecological oncology (-0.7%). These estimates include the full impact of the CF change displayed in Table 1, the loss of the 1.0 physician work GPCI floor, and service specific RVU changes.

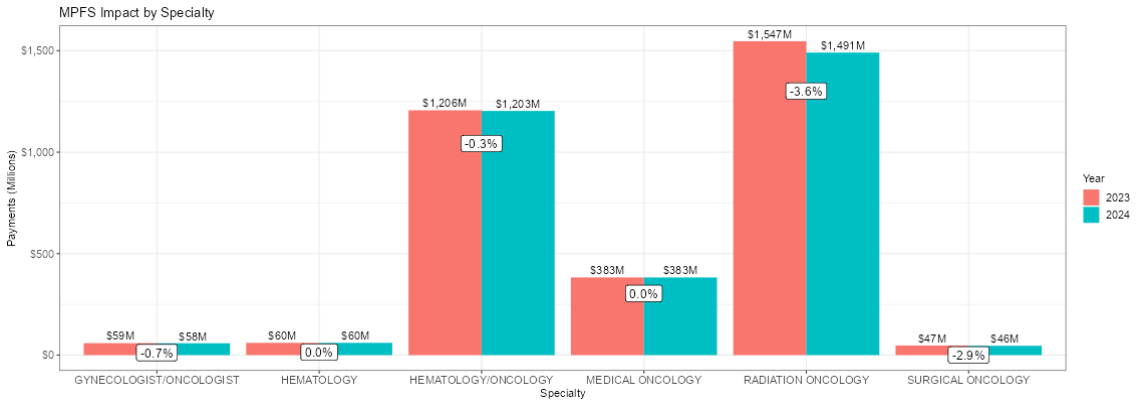

Figure 1. Current and Proposed Medicare Part B Payments by Oncology Specialty

Changes in Physician Work Valuation

In the CY 2021 MPFS final rule, CMS accepted the American Medical Association RVS Update Committee's recommended increases in physician wRVUs for office/outpatient visits. CMS also added a new add-on code, G2211 for complex visits. Complexity was not defined based on level of service, but rather for "primary medical care services that serve as the continuing focal point for all needed health care services." In other words, internal medicine specialties would benefit from G2211, whereas surgical and other specialties would not be expected to bill this code regularly. In their analysis for 2021, CMS assumed that hematology/oncology would add G2211 to 90% of visits.

The increased valuation of office/outpatient visits, combined with the addition of G2211, resulted in a proposed -10% budget neutrality adjustment for 2021, significantly decreasing reimbursement for non-cognitive services. In CAA, 2021, Congress stopped CMS from paying for G2211 and provided a temporary increase in the CF to negate decreases due to the new wRVUs for office/outpatient visits. The temporary hold on payment for G2211 expires at the end of 2023. CMS is proposing to pay for G2211 starting in 2024. CMS proposes lowering their utilization assumptions, predicting that G2211 will be added to 38% of all office/outpatient visits. While CMS does not restrict individual specialties from applying this code, their proposed policy discriminates against certain specialties in multiple ways. First, G2211 applies only to office/outpatient visits and not to other places of service. Second, CMS assumes certain specialties, including surgical oncology, will only add G2211 to new patient visits. Third, G2211 will not be allowed for visits paired with a "minor procedure" (i.e., G2211 may not be added to visits billed with a -25 modifier). For hematology/oncology, the third restriction impacts visits in the office setting, where a -25 modifier is required for visits on the same day as drug administration; this restriction does not apply to the outpatient hospital setting where drug administration is billed by the facility.

Lastly, neither the 2021 increase in wRVUs for office/outpatient visits, nor the addition of G2211 in 2024, increases reimbursement for global services. Global services, including many surgeries and radiation treatment management, include the provision of a certain number of E&M services. When CMS accepted new wRVUs and added G2211 to office/outpatient visits, they declined to update the values for global services. This has resulted in drastic changes in total wRVUs per specialty. Since 2020, hematology/oncology has experienced a 22% increase in wRVUs for the same set of services, whereas radiation oncology has experienced only a 2% increase for their services (Figure 2). While a 22% increase in wRVUs for hematology/oncology may be expected to result in increased compensation for physicians, both independent and hospital-based practices must account for reductions in payment for other services and overall payments which fail to sufficiently meet increased labor, supply, and equipment costs. The result is that employers have decreased compensation per wRVU for many productivity-driven contracts.

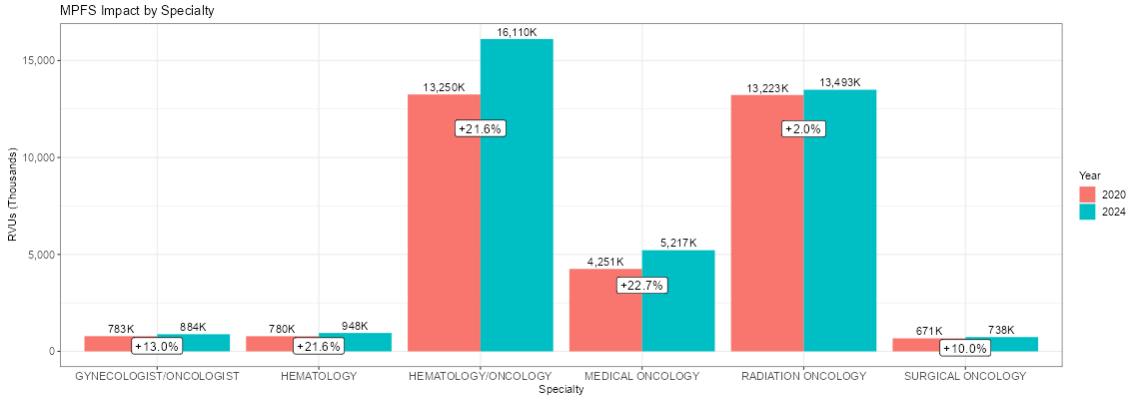

Figure 2. Cumulative Change to Total Physician Work RVUs, from 2020 to 2024

Changes to Clinical Labor Expense

Medicare allowable rates are calculated from the combination of wRVUs, practice expense RVUs (peRVUs), and malpractice RVUs (mpRVUs), adjusted geographically—Medicare uses GPCIs to adjust RVUs for each locality—and through annual changes in the MPFS CF.

Medicare Allowable =
*(Work RVU * Work GCPI +*
[Direct Practice Expense RVU {Clinical Labor + Supplies + Equipment} +
*Indirect Practice Expense RVU] * Practice Expense GPCI +*
*Malpractice RVU * Malpractice GPCI) **
Conversion Factor

The calculation of clinical labor expenses is based on the labor class used in the performance of each service (e.g., RN/OCN); time estimates for pre-, intra-, and post-service work; and a pay/benefit rate per minute. Rates per minute are based on Bureau of Labor Statistics or other sources. In the 2022 MPFS final rule, CMS initiated a four-year phase-in to update the pricing for clinical labor rates.

For most labor codes, rates per minute had not been updated for 20 years (i.e., since the 2002 MPFS final rule). As a result, direct practice expenses have been grossly underestimated for many years. For 2024, CMS proposes to implement the third year of its clinical labor pricing update. A simplified example of the transition from the 2002 pricing to the fully implemented new pricing that CMS finalized in the CY2022 MPFS final rule is provided in Table 2. Labor codes and rates per minute common to oncology services are displayed in Table 3.

Current Price (2002)	**$1.00**	
Final Price	**$2.00**	
Year 1 (CY 2022)	$1.25	1/4 difference between $1.00 and $2.00
Year 2 (CY 2023)	$1.50	1/3 difference between $1.25 and $2.00
Year 3 (CY 2024)	$1.75	1/2 difference between $1.50 and $2.00
Final (CY 2025)	$2.00	

Table 2. Example of Clinical Labor Pricing Transition

	Original (CY 2021) Rate per Minute	Year 3 (CY 2024) Rate per Minute	Final (CY 2025) Rate per Minute
L037D – RN/LPN/MTA	0.37	0.498	0.54
L042A – RN/LPN	0.42	0.578	0.63
L051A – RN	0.51	0.698	0.76
L056A – RN/OCN	0.79	0.805	0.81
L050C – Radiation Therapist	0.50	0.783	0.89
L063A – Medical Dosimetrist	0.63	0.840	0.91
L107A – Dosimetrist/Physicist	1.08	1.409	1.52
L152A – Medical Physicist	1.52	1.986	2.14

Table 3. Selected Clinical Labor Inputs

Also embedded within the calculation of the peRVUs is a budget neutrality mechanism titled "direct scaling adjustment" which converts actual labor, supply, and equipment expenses to adjusted values. If specific direct practice expenses increase or decrease, contraposed changes to the direct scaling adjustment keep the total number of direct peRVUs equal to the prior year.

From 2017 to 2020, peRVUs were calculated using a direct scaling adjustment of between 0.57 and 0.59. Since 2021, increases to labor expenses precipitated decreases in the direct scaling adjustment: a reduction to 0.5094 in 2022 and 0.5010 in 2023. The proposed direct scaling adjustment for 2024 is 0.4639 (Figure 3). In other words, to pay for increases to direct labor, rates for all direct expenses have decreased by 22% and this amount is expected to decrease further in 2025.

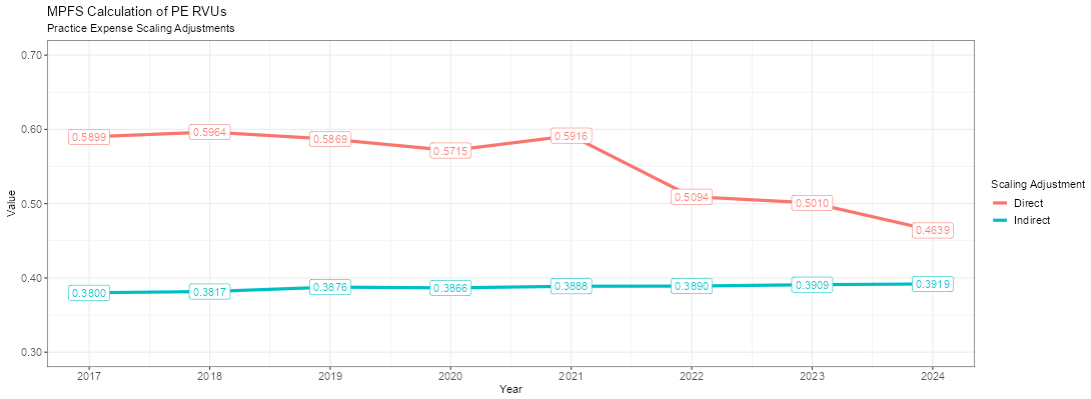

Figure 3. Direct Scaling Adjustment Used to Determine Direct Practice Expense RVUs, by Calendar Year

Tables 4 and 5 demonstrate how direct costs are converted to peRVUs. In the case of 96413 (chemotherapy intravenous injection/infusion), the modest increase to calculated direct costs is not sufficient to overcome the 22% decrease to the direct scaling adjustment and 6.1% decrease to the conversion factor that have occurred since 2021. For G6015 (intensity modulated radiation treatment delivery), despite a 58% increase to reported labor costs, application of the direct scaling adjustment and conversion factor, when applied to equipment and supplies, results in a 13% decrease in direct cost reimbursement.

	2021 Final Rule	2024 Proposed Rule	% Change
Labor Cost	77.42	78.89	1.9%
Supply Cost	22.55	23.68	5.0%
Equipment Cost	1.52	1.65	8.6%
Direct Cost	101.50	103.73	2.2%
Direct Scaling Adjustment	*0.5916*	*0.4639*	*-22%*
Adjusted Labor Cost	45.80	36.60	-20%
Adjusted Supply Cost	13.34	10.99	-18%
Adjusted Equipment Cost	0.90	0.77	-15%
Adjusted Direct	60.05	48.12	-20%
*Prior Conversion Factor**	*36.0896*	*33.0607*	*-8.4%*
Labor Cost Converted	1.27	1.11	-13%
Supply Cost Converted	0.37	0.33	-10%
Equipment Cost Converted	0.02	0.02	-7.1%
Direct Cost Converted	1.66	1.46	-13%
New Conversion Factor	*34.8931*	*32.7476*	*-6.1%*
Labor Cost Reimbursement	44.31	36.35	-18%
Supply Cost Reimbursement	12.91	10.81	-16%
Equipment Cost Reimbursement	0.70	0.65	-6.1%
Total Direct Cost Reimbursement	**57.92**	**47.81**	**-17%**

Table 4. Calculated Direct Practice Expense for 96413, Chemotherapy IV, Non-Facility
** The practice expense calculator uses the prior year's CF, excluding any temporary increases*

	2021 Final Rule	2024 Proposed Rule	% Change
Labor Cost	33.61	53.04	58%
Supply Cost	16.80	18.89	12%
Equipment Cost	350.48	360.52	2.9%
Direct Cost	400.88	432.45	7.9%
Direct Scaling Adjustment	*0.5916*	*0.4639*	*-22%*
Adjusted Labor Cost	19.88	24.61	24%
Adjusted Supply Cost	9.94	8.76	-12%
Adjusted Equipment Cost	207.34	167.25	-19%
Adjusted Direct	237.16	200.61	-15%
*Prior Conversion Factor**	*36.0896*	*33.0607*	*-8.4%*
Labor Cost Converted	0.55	0.74	35%
Supply Cost Converted	0.28	0.27	-3.6%
Equipment Cost Converted	5.75	5.06	-12%
Direct Cost Converted	6.57	6.07	-7.6%
New Conversion Factor	*34.8931*	*32.7476*	*-6.1%*
Labor Cost Reimbursement	19.19	24.23	26%
Supply Cost Reimbursement	9.77	8.84	-10%
Equipment Cost Reimbursement	200.64	165.70	-17%
Total Direct Cost Reimbursement	**229.25**	**198.78**	**-13%**

Table 5. Calculated Direct Practice Expense for G6015, IMRT Delivery, Non-Facility
** The practice expense calculator uses the prior year's CF, excluding any temporary increases*

Impact on Specific Oncology Services

The combined effect of G2211, reductions in the direct scaling adjustment and MPFS CF, and loss of the 1.0 floor for the work GPCI, produces changes in reimbursement unique to each category of services. Reimbursement for office/outpatient visits will decrease an average of 2% in 2024, except when adding G2211, which will increase total reimbursement for certain visits between 7.3% to 69%, depending on the level of service (Table 6).

	2023 RVU	2024 RVU	2022 NPR	2023 NRP	% Change
99202 - Office/Outpatient Visit, New, Level 2	2.15	2.17	72.86	71.06	-2.5%
99203 - Office/Outpatient Visit, New, Level 3	3.33	3.35	112.84	109.70	-2.8%
99204 - Office/Outpatient Visit, New, Level 4	4.94	5.02	167.40	164.39	-1.8%
99205 - Office/Outpatient Visit, New, Level 5	6.52	6.62	220.94	216.79	-1.9%
99211 - Office/Outpatient Visit, Established, Level 1	0.69	0.70	23.38	22.92	-2.0%
99212 - Office/Outpatient Visit, Established, Level 2	1.68	1.70	56.93	55.67	-2.2%
99213 - Office/Outpatient Visit, Established, Level 3	2.68	2.73	90.82	89.40	-1.6%
99214 - Office/Outpatient Visit, Established, Level 4	3.79	3.85	128.43	126.08	-1.8%
99215 - Office/Outpatient Visit, Established, Level 5	5.31	5.42	179.94	177.49	-1.4%
G2211 - Complex E&M Visit, Add On	0	0.49	0.00	16.05	

Table 6. Relative Value Unit and Medicare Allowable Impact for Office/Outpatient Visits, Non-Facility Place of Service

Within infusion and radiation services, the decrease in the direct scaling adjustment and conversion factor results in reduced payments for most codes (Table 7, Figure 3, and Table 8).

	2023 RVU	2024 RVU	2022 NPR	2023 NRP	% Change
96360 - IV infusion, hydration, 31 minutes to 1 hour	0.97	0.97	32.87	31.77	-3.3%
96361 - IV infusion, hydration, each additional hour	0.38	0.37	12.88	12.12	-5.9%
96365 - IV infusion, non-chemo, initial, up to 1 hour	1.91	1.88	64.72	61.57	-4.9%
96366 - IV infusion, non-chemo each additional hour	0.61	0.61	20.67	19.98	-3.3%
96367 - IV infusion, non-chemo, additional drug	0.86	0.85	29.14	27.84	-4.5%
96368 - Concurrent infusion	0.59	0.59	19.99	19.32	-3.4%
96372 - Non-chemo injection, sc or im	0.42	0.43	14.23	14.08	-1.1%
96374 - IV push, non-chemo, initial	1.11	1.10	37.61	36.02	-4.2%
96375 - IV push, non-chemo, additional drug	0.46	0.46	15.59	15.06	-3.4%
96377 - Application on-body injector	0.55	0.55	18.64	18.01	-3.4%
96401 - Chemo admin, sc or im, non-hormonal	2.17	2.15	73.54	70.41	-4.3%
96402 - Chemo admin, sc or im, hormonal	1.01	1.06	34.23	34.71	1.4%
96409 - Chemo admin, iv push, initial	3.01	3.00	102.00	98.24	-3.7%
96411 - Chemo admin, iv push, additional drug	1.65	1.63	55.91	53.38	-4.5%
96413 - Chemo admin, iv infusion, initial, up to 1 hour	3.90	3.88	132.16	127.06	-3.9%
96415 - Chemo admin, iv infusion, each additional hour	0.84	0.83	28.47	27.18	-4.5%
96416 - Chemo admin, prolonged iv infusion (>8 hours)	3.83	3.82	129.79	125.10	-3.6%
96417 - Chemo admin, iv infusion, additional drug	1.92	1.91	65.06	62.55	-3.9%

Table 7. Relative Value Unit and Medicare Allowable Impact for Drug Administration Codes

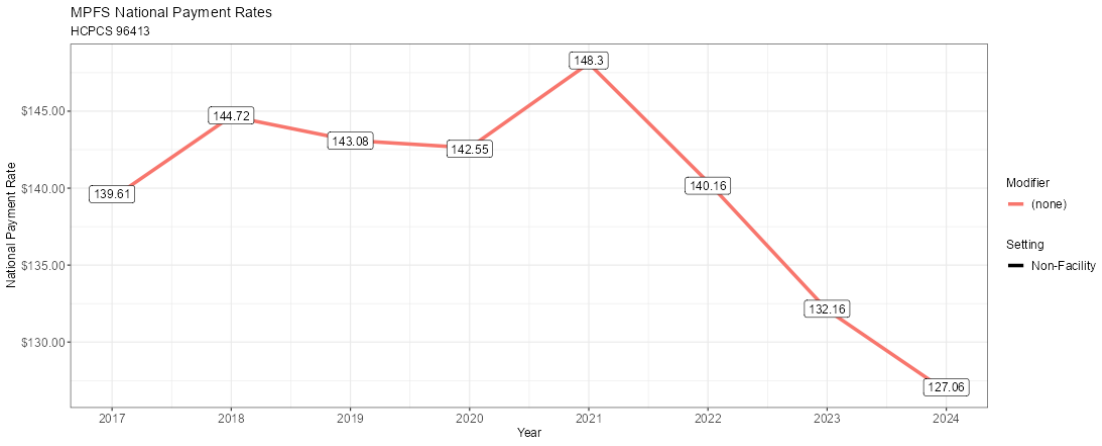

Figure 4. National Payment Rate for 96413, Chemotherapy IV, Non-Facility

	2023 RVU	2024 RVU	2022 NPR	2023 NRP	% Impact
G6003 - Radiation tx delivery, simple, ≤5 MV	2.23	2.26	75.57	74.01	-2.1%
G6004 - Radiation tx delivery, simple, 6-10 MV	3.86	3.79	130.80	124.11	-5.1%
G6005 - Radiation tx delivery, simple, 11-19 MV	3.87	3.81	131.14	124.77	-4.9%
G6006 - Radiation tx delivery, simple, ≥20 MV	3.85	3.77	130.47	123.46	-5.4%
G6008 - Radiation tx delivery, intermediate, 6-10 MV	5.33	5.23	180.62	171.27	-5.2%
G6009 - Radiation tx delivery, intermediate, 11-19 MV	5.31	5.23	179.74	171.27	-4.7%
G6010 - Radiation tx delivery, intermediate, ≥20 MV	5.28	5.19	178.92	169.96	-5.0%
G6011 - Radiation tx delivery, complex, ≤5 MV	7.11	6.88	240.94	225.30	-6.5%
G6012 - Radiation tx delivery, complex, 6-10 MV	7.03	6.89	238.23	225.63	-5.3%
G6013 - Radiation tx delivery, complex, 11-19 MV	7.05	6.92	238.90	226.61	-5.1%
G6014 - Radiation tx delivery, complex, ≥20 MV	7.01	6.87	237.55	224.98	-5.3%
G6015 - Radiation tx delivery, IMRT	10.77	10.68	364.97	349.74	-4.2%

Table 8. Relative Value Unit and Medicare Allowable Impact for Radiation Treatment Delivery

Place of Service and State Specific Impact

ASCO previously used PracticeNET data to calculate impact for individual practices. PracticeNET data were based on the 50 health care organizations participating and providing data. We are now shifting the basis of our analysis to national datasets. While national datasets do not allow us to calculate the impact for individual practices, we can consider place of service (office, outpatient hospital, or other) and include all 53 Medicare states and territories.

Based on national data, we project hematology/oncology payments to decrease 0.4% for services performed in the office setting and 4.0% in the inpatient hospital setting. For services performed in outpatient hospital settings, the professional component of payments is expected to increase by 2.5% (Figure 5). All outpatient settings are expected to benefit from the creation of G2211, but the office setting has two key differences: a) the limitation on use of G2211 when the visit is paired with a procedure necessitating use of modifier -25; and b) reduction in reimbursement of direct practice expenses for other services.

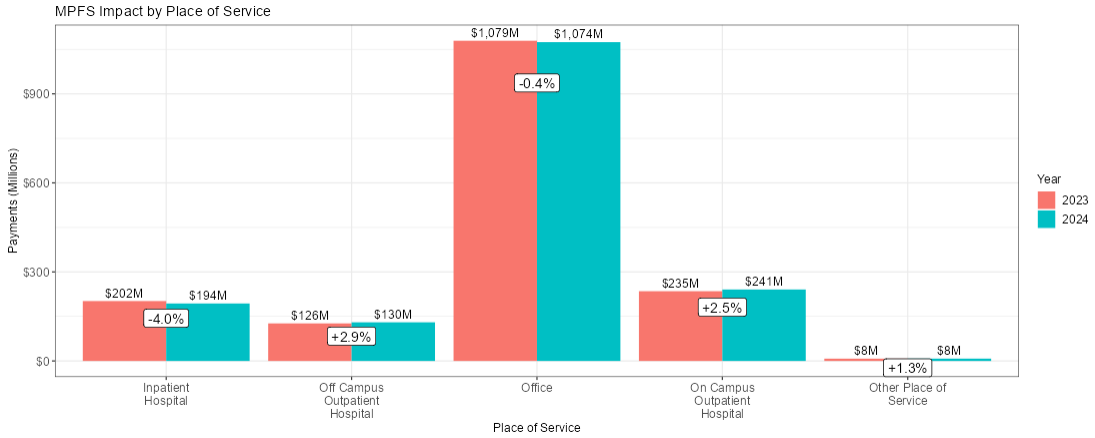

Figure 5. MPFS Impact, by Place of Service, for Hematology/Oncology

Within radiation oncology, payments are expected to decrease in all settings. Because most office/outpatient visits are bundled into a global period during treatment, radiation oncology will

receive little benefit from G2211 and will experience decreases in the direct scaling adjustment and MPFS CF (Figure 6).

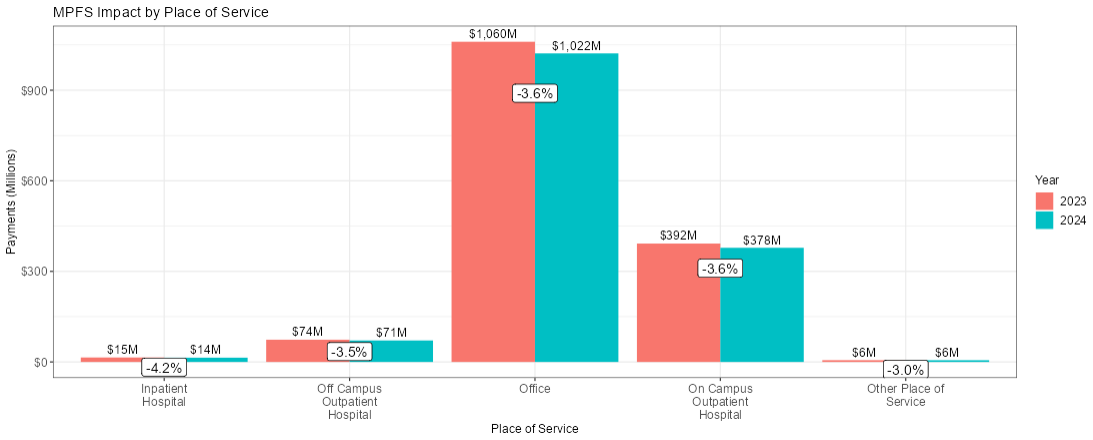

Figure 6. MPFS Impact, by Place of Service, for Radiation Oncology

At a state level, the loss of the 1.0 floor for the physician work GPCI results in further disparities in reimbursement. When considering all oncology specialties, the impact to individual states ranges from -3.7% in Alabama to -0.2% in Washington State (Figure 7).

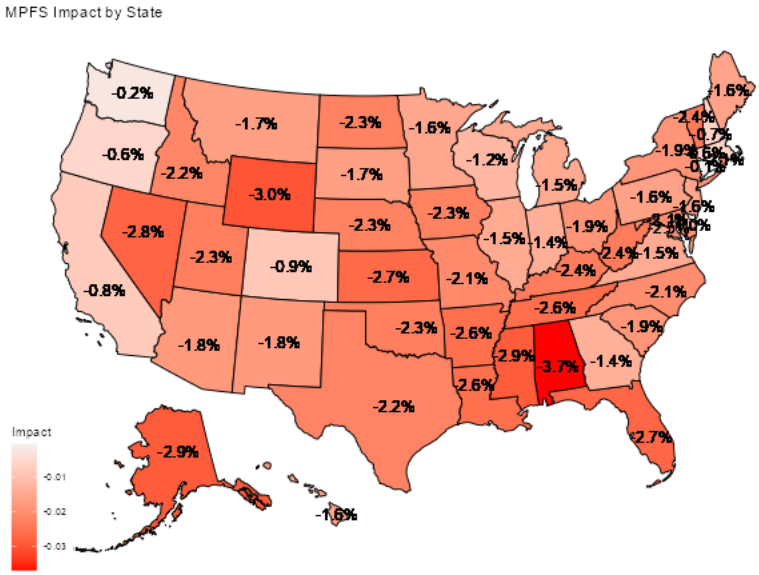

Figure 7. State-Specific Impact of the 2024 MPFS Proposed Rule, All Oncology Specialties

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Notes on This Year's Change in Methodology

In prior years, analysis on the MPFS was completed utilizing PracticeNET data. PracticeNET had the benefit of calculating practice-specific impacts and uncovering details on the analysis that may not be easily discoverable with national totals included in Medicare's data release. PracticeNET was discontinued earlier this month, necessitating use of a new dataset.

This year's analysis was constructed using multiple publicly available datasets:

- The Physician/Supplier Procedure Summary file is a publicly available dataset included on data.cms.gov. This dataset, released annually, gives summary service counts, charges, and payments for Medicare Part B carrier and durable medical equipment fee-for-service claims. It is organized by billing code, modifier, provider specialty, place of service, carrier, and pricing locality. While sourced from 100% of Part B claims, this dataset has a limitation in that any data rows representing 10 or fewer beneficiaries for the given year are suppressed for privacy reasons—i.e., if 10 or fewer beneficiaries receive the same service, with the same modifier, provider specialty, locality, etc., the dataset will not display relevant facts, other than total payment amount. 99% of MPFS payments are displayed in this dataset. Use of this dataset provides the multiplier for each measure in the analysis.
- The following files are posted in conjunction with MPFS proposed and final rules:
    - Addendum B Relative Value Units (RVU) and Related Information – this dataset includes physician work relative value units (wRVU), practice expense work relative value units (peRVU), and malpractice relative value units (mpRVU) for each service priced in the proposed rule. These values are used as multiplicands for the RVU-based measures and are used in calculation of national and locality-specific payment rates.
    - Geographic Practice Cost Indices (GPCI) – this dataset includes locality-specific ratios, with a typical weighted average of 1.0, for physician work, practice expense, and malpractice, that reflects costs differences between localities. When applied to national wRVU, peRVU, and mpRVU amounts, summarized, and multiplied by national conversion factor (CF), the resulting product is locality-specific payment rates.
- The following reference files were also used to assist in dimensional analysis:
    - Specialties – a list of specialty codes, names, and indirect practice expense assignments.
    - Restructured BETOS Classification System – a list of billing codes and assigned service categories—e.g., Current Procedural Terminology Code (CPT) 99214 is assigned a subcategory of "Office/Outpatient Services."