

November 2, 2022

AHA Summary of Physician Fee Schedule Final Rule for CY 2023

The Centers for Medicare & Medicaid Services (CMS) Nov. 1 issued a [final rule](#) that updates the physician fee schedule (PFS) for calendar year (CY) 2023. The rule also includes changes related to the Medicare Shared Savings Program and the Quality Payment Program (QPP), both of which were created by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

KEY HIGHLIGHTS

The final rule:

- Reduces the PFS conversion factor to \$33.06 in CY 2023, as compared to \$34.61 in CY 2022, which reflects: the expiration of the temporary 3% statutory payment increase; a 0.0% conversion factor update, as required by law; and a budget-neutrality adjustment.
- Updates the Medicare Economic Index weights for CY 2023, although the revised weights were not used in CY 2023 ratesetting.
- Delays for one year (until Jan. 1, 2024) CMS' implementation of its policy to define the substantive portion of a split (or shared) visit based on the amount of time spent by the billing practitioner.
- Adds several temporary telehealth codes to be available until the end of 2023 on a Category 3 basis, extends certain telehealth flexibilities through 151 days after the COVID-19 PHE expires in accordance with the Consolidated Appropriations Act and updates the originating site fee.
- Provides advance shared savings payments to “low-revenue” Accountable Care Organizations (ACOs) that are both new to the MSSP and serve underserved populations and increases flexibility for these ACOs to share in savings.
- Provides ACOs a more gradual glide path to two-sided risk.
- Modifies the ACO benchmarking methodology to help ensure that ACOs do not have to compete against their own best performance.
- Modifies Medicare Shared Savings Program (MSSP) quality scoring by adopting a sliding scale for shared-savings eligibility and adding a new health equity adjustment.
- Adds five new Merit-Based Incentive Payment System Value Pathways (MVPs) for CY 2023.
- Increases the quality data completeness threshold to 75% and revises Promoting Interoperability objectives and measures.

AHA TAKE

The AHA is concerned with CMS' payment update, which reduces CY 2023 payments from their CY 2022 levels by almost 4.5%, and, as a result, may have a negative impact on patients' access to certain services. Our concern is heightened by the fact that this cut is coming in the wake of nearly two years of unrelenting financial pressures on the health care system due to the ongoing COVID-19 public health emergency (PHE), increased inflation, rising staffing costs and increased costs for non-labor supply categories due to national shortages. However, we are pleased that CMS is delaying implementation of its split/shared visit policy, which would have resulted in a significant reduction in physician revenue on top of this proposed rule's other cuts.

Additionally, while the rule does add many telehealth services for continued coverage through 2023 and extends certain additional flexibilities for 151 days after the COVID-19 PHE ends, we are concerned about the "telehealth cliff" that will result after the PHE expires, potentially creating reductions in access and services. The AHA continues to encourage CMS to work with Congress on permanent adoption of waiver provisions such as eliminating the originating and geographic site restrictions for all telehealth services and expanding telehealth eligibility to certain practitioners.

We are encouraged by the modifications made in the CY 2023 final rule on the MSSP and Quality Payment Programs, which reflect many priorities on which we have worked with the agency. For MSSP for example, the final rule modifies the manner in which ACOs' benchmarks are calculated to help sustain long-term participation and reduce costs. It also provides increased flexibility for certain smaller ACOs to share in savings. We continue to encourage CMS to adopt policies that support flexible implementation and widespread adoption of value-based and alternative payment models.

Highlights of the PFS rule follow:

CY 2023 Proposed Payment Update

CMS will reduce the conversion factor to \$33.06 in CY 2023, as compared to \$34.61 in CY 2022 (a 4.48% decrease). This update reflects several different factors: the expiration of a temporary 3% increase in the PFS conversion factor, which was provided by the Protecting Medicare and American Farmers From Sequester Cuts Act for CY 2022 only; a 0% update factor as required by MACRA; and a budget-neutrality adjustment.

Updated Medicare Economic Index (MEI) for CY 2023

The agency finalized rebasing of the MEI, incorporating recommendations received based on public comment. Under the agency's revised methodology, the portion of the MEI accounted for by practice expense increased, while the portions accounted for by physician work and malpractice decreased. The agency anticipates that these revised

weights will not impact overall spending for PFS services, but will impact distribution of payments based on geography and specialty. Therefore, the revised MEI weights were not used in CY 2023 ratesetting. The updated MEI for CY 2023 is 3.8% based on data available.

Changes to Payment for Medicare Telehealth Services

In the CY 2021 PFS final rule, CMS created a new category — Category 3 — for adding services on a temporary basis to Medicare’s approved list of telehealth services. Coverage and payment for Category 3 services will be retained until the end of CY 2023. In this year’s rule, CMS adds 54 additional services to Category 3, in order to continue to collect data and evaluate whether these codes would warrant adoption on a permanent basis.

Regarding services that are temporarily included on the telehealth list during the COVID-19 PHE, but not on a Category 1, 2 or 3 basis, CMS will maintain these services on the list for 151 days following the end of the PHE, as required by the Consolidated Appropriations Act, 2022 (CAA, 2022). Notably, CMS decided audio-only telephone evaluation and management coverage outside of behavioral health will not be extended until the end of 2023. The final rule also reiterated that two-way, audio-video communications technology will continue to be the appropriate standard of care that will apply for Medicare telehealth services after the COVID-19 PHE and the 151-day extension period.

Also as required under the CAA, 2022, CMS extends certain additional flexibilities for 151 days after the COVID-19 PHE ends, including waiving the geographic and originating site restrictions; allowing certain services to be furnished via audio-only telecommunications systems; and allowing payment for Rural Health Clinics and Federally Qualified Health Centers for furnishing telehealth services (other than mental health visits that can be furnished virtually on a permanent basis). The CAA, 2022 also delays the in-person visit requirements for mental health services furnished via telehealth until 152 days after the end of the PHE.

Additionally, the originating site fee was updated from \$27.59 to \$28.64 for CY 2023. This reflects the 3.8% MEI increase for CY 2023.

Payment for Evaluation and Management (E/M) Visits

A “split” or “shared” E/M visit is one that is performed by both a physician and a non-physician practitioner (NPP) in the same group. Because Medicare provides higher PFS payment for services furnished by physicians than those furnished by NPPs, CMS has addressed when physicians can bill for split visits. Specifically, physicians in a facility setting may bill for an E/M visit when both the billing physician and an NPP in the same group each perform portions of the visit, but only if the physician performs a “substantive” portion of the visit. If the physician does not perform a substantive part of

the split visit and the NPP bills for it, Medicare will pay only 85% of the fee schedule rate.

In last year's rulemaking, CMS finalized a policy under which the agency would define the "substantive" portion of the visit as more than half of the total time spent. This was scheduled to take effect in CY 2023. However, CMS in the CY 2023 final rule delays implementation of this policy for one year, until Jan. 1, 2024. Thus, for CY 2023, the substantive portion continues to be defined as either one of the three key components of a visit (history, physical exam or medical decision-making), or more than half of the total time.

Requiring Manufacturers of Certain Single-dose Container or Single-dose Package Drugs to Provide Refunds with Respect to Discarded Amounts

The Infrastructure Investment and Jobs Act requires manufacturers to provide a refund to CMS for certain discarded amounts from a single-dose container or single-use package drug. The refund amount is the amount of discarded drug that exceeds an applicable percentage, which is required to be at least 10% of total charges for the drug in a calendar quarter. A refundable single-dose container or single-use package drug does not include the following: radiopharmaceutical or imaging agents; certain drugs requiring filtration; and certain new drugs.

To implement this requirement, CMS is finalizing policies including: how providers will determine the amount of discarded drugs; how they will record these amounts on the bill; and a definition of which drugs are subject to refunds. This includes a policy that hospital outpatient departments (HOPDs) and ambulatory surgery centers (ASCs) be required to report the JW modifier, or any successor modifier, to identify discarded amounts of refundable single-dose container or single-use package drugs that are separately payable under the OPSS (described by HCPCS codes assigned status indicator "K" or "G") or ASC payment system (described by HCPCS codes assigned payment indicator "K2").

Specifically, CMS finalizes a policy that, starting Jan. 1, 2023, for the purpose of calculating the refund amount during a relevant quarter, the JW modifier be used to determine the total number of billing units of the Health Care Common Procedure Coding System (HCPCS) code of a refundable single-dose container or single-use package drug that were discarded. Further, beginning no later than July 1, 2023, CMS also will require HOPDs and ASCs to use a separate modifier, JZ, in cases where no billing units of such drugs were discarded and for which the JW modifier would be required if there were discarded amounts. The agency will begin claims edits for both the JW and JZ modifier beginning Oct. 1, 2023.

Medicare Shared Savings Program (MSSP)

CMS adopted numerous policy changes to the Medicare Shared Savings Program, many of which the AHA has advocated for. The modifications in the final rule intend to support improved equity and expanded access for underserved populations.

Modifications for Smaller ACOs. In the final rule, CMS added a new option in the MSSP to make advanced shared savings payments to support certain ACOs in covering upfront infrastructure investments. ACOs eligible for these payments are those that are a) new to the MSSP and b) identified as being low-revenue and inexperienced with ACO performance-based risk. They may receive a one-time fixed payment of \$250,000, as well as quarterly payments for the first two years of the five-year agreement period. The advance investment payments would be recouped once the ACO begins to achieve shared savings, if the ACO doesn't achieve shared savings then funding will not be recouped (unless the ACO terminates during the agreement period in which advance investment payments were made). ACOs must use these payments to improve health care provider infrastructure, increase staffing, or provide accountable care for underserved beneficiaries, which may include addressing social needs. The initial application cycle to apply for advance investment payments will occur during CY 2023 for a Jan. 1, 2024, start date.

In addition, beginning on Jan. 1, 2024, CMS will provide more flexibility in how certain ACOs can qualify for shared savings, including allowing certain low-revenue ACOs in the BASIC track to share in savings, even if the ACO does not meet the minimum savings rate (MSR) requirement. That is, eligible ACOs that meet the quality performance standard required to share in savings at the maximum sharing rate, but not the MSR itself, would receive half of the maximum sharing rate for their level of participation.

Transition to Performance-based Risk. In response to feedback from AHA and other stakeholders that the MSSP requires too much risk too soon, CMS adopted proposals to provide more gradual transitions for certain ACOs. For example, for agreement periods beginning on Jan. 1, 2024, the final rule enables ACOs inexperienced with performance-based risk to participate in the lowest risk level (BASIC Track, Level A), for all five years of the agreement period. These ACOs may be eligible for a second agreement period within the BASIC track's glide path, with two additional years under one-sided models (Levels A and B), for a total of seven years before transitioning on to two-sided risk (Levels C, D and E). For performance years beginning Jan. 1, 2023, and Jan. 1, 2024, the agency would allow ACOs currently participating in Levels A or B to elect to remain there for the remainder of their agreement.

Lastly, for agreement periods beginning on Jan. 1, 2024, and after, CMS will allow an ACO to remain in Level E of the BASIC track indefinitely; participation in the ENHANCED track will be optional.

Modifications to ACO Benchmarks. CMS makes numerous changes designed to improve the calculation of ACO benchmarks so as to encourage participation in the

program, including by helping to ensure that an ACO does not have to compete against its own best performance. For example, the agency:

- Adopted its proposal to use a prospectively projected administrative growth factor, a variant of the United States Per Capita Cost (USPCC) referred to as the Accountable Care Prospective Trend (ACPT), in addition to national and regional growth rates when updating benchmarks. The agency believes that this three-way blended growth factor will help insulate the benchmarks from savings achieved under the MSSP. Additionally the ACPT growth factors will be set for the ACO's entire agreement period, providing some level of stability.
- Adopted its proposal to incorporate an adjustment for prior savings into the benchmark for returning/renewing ACOs. CMS believes that returning dollar value to benchmarks through a prior-savings adjustment will help address the ratcheting effect whereby ACOs must continually beat their own performance and will incentive high performing ACOs to remain in the program.
- Modifies the cap on risk-score increases so that they can increase by more than 3% from the base year to any performance year, which is the current standard.

The agency also adopted certain benchmarking policies to mitigate the impact of regional adjustments and support participation by organizations serving medically complex high-cost beneficiaries.

Quality Performance Standard. Current MSSP policy requires ACOs to meet a minimum “quality performance standard” in order to be eligible for shared savings or avoid owing maximum losses. That standard is the 30th percentile of MIPS quality scores for CY 2023, and the 40th percentile for CY 2024 and beyond. Beginning with the 2023 performance year, ACOs scoring below the minimum quality performance standard will be eligible for shared savings (or owe shared losses) at a lower rate if they score at the 10th percentile or above on at least one of the four APM Performance Pathway (APP) outcomes measures used in the MSSP. The lower rates of shared savings/losses will be calculated on a sliding scale tied to the ACO's quality performance score. CMS states that the intent of the modified policy is to avoid a “cliff” in which small differences in quality score could eliminate any possibility of shared savings, or lead to owing shared losses.

CMS also finalizes its proposal to retain through performance year 2024 its incentive for ACOs to report the APP measure set. ACOs that opt to report the APP measure set will meet the minimum quality performance standard if they achieve both:

- A score of at least the 10th percentile on at least one of the four APP outcome measures; and
- A score at or above the 40th percentile on least one of the other five APP measures.

Health Equity Adjustment. Beginning in CY 2023, CMS will add up to 10 bonus points to an ACO's quality performance score based on a combination of their quality

performance and the extent to which they care for underserved patients. The bonus will be available to only those ACOs that opt to report the six measures in the APP measure set. The equity adjustment will be the product of two factors — a “measure performance scaler” and “an underserved multiplier.” The measure performance scaler is unchanged from the proposed rule, and will assign ACOs points on each APP measure based on whether they score in the top, middle or bottom third of performance on the measure. However, CMS adopts a modification to the underserved multiplier by including assigned beneficiaries that receive the Medicare Part D Low Income Subsidy (LIS). As a result, the underserved multiplier will be the higher of the ACO’s Area Deprivation Index (ADI) score or its proportion of beneficiaries who are dually eligible for Medicare and Medicaid or receive the Part D LIS.

Behavioral Health

Currently, payment for services of licensed professional counselors and licensed marriage and family therapists can only be made under the PFS indirectly (i.e. when delivered incident to the services and under direct supervision of—as opposed to independent of—the billing physician or other practitioner). CMS finalized its proposal to amend the direct supervision requirement to allow behavioral health services to be furnished under the *general* supervision of a physician or NPP when the services are provided by auxiliary personnel incident to the services of a physician or NPP.

In addition, CMS establishes a new code as part of the existing set of codes describing services furnished using the Psychiatric Collaborative Care Model. This code accounts for monthly care integration where the mental health services furnished by a clinical psychologist or clinical social worker (as opposed to a physician) serve as the “focal point” of care integration and would be allowed under general supervision.

Opioid Treatment Programs (OTPs)

Due to the unreliable nature of voluntary reporting of average sales price (ASP) data for various forms of methadone, CMS believes that the ASP data cannot provide an appropriate reflection of methadone costs for OTPs, and thus will use a different method of updating the payment rate for the drug component of the methadone weekly bundle and add-on code for take-home supplies of methadone. Under this provision, CMS will use the payment amount used in CY 2021 (rather than more recent pricing data, which would result in a decrease in payments) and update the amount annually to account for inflation.

CMS will also update the rate for individual therapy (the non-drug component) of the bundled payment. This rate is currently based on a crosswalk to a code that describes 30 minutes of psychotherapy, but stakeholder feedback leads CMS to believe that the severity of needs of the patient population diagnosed with OUD and receiving services in the OTP setting is generally greater than that of patients receiving 30-minute psychotherapy services paid under the PFS. Thus, the agency will instead crosswalk to a code (CPT code 90834) describing 45 minutes of psychotherapy.

Finally, CMS finalized its proposal to allow the OTP intake add-on code to be furnished via two-way audio-video communications technology for the initiation of treatment with buprenorphine under certain circumstances. In addition, CMS will allow periodic assessments to continue to be furnished using audio-only communication technology through the end of CY 2023.

Requirements for Electronic Prescribing for Controlled Substances (ECPS)

Section 2003 of the SUPPORT Act requires prescribers to use ECPS for a Part D drug covered under a prescription drug plan or a Medicare Advantage prescription drug plan. In the CY 2020 PFS final rule, CMS stated that it would begin initial ECPS compliance actions beginning in CY 2023. CMS notes that it will use Prescription Drug Event data from the year in which compliance is being evaluated as soon as that data become available; hence, it will evaluate compliance in CY 2023 when it gets 2023 data in 2024. CMS will extend the non-compliance action of sending letters to non-compliance prescribers through 2024.

Quality Payment Program (QPP)

As mandated by MACRA, the QPP includes two tracks — the default Merit-Based Incentive Payment System (MIPS) and advanced alternative payment models (APMs). The rule proposes updates to what eligible clinicians must report during the QPP's 2023 performance period and beyond. There is a lag of two years between the QPP's performance period and the payment year; for example, CY 2023 performance will affect PFS payments in CY 2025. As required by MACRA, eligible clinicians will receive positive or negative payment adjustments of up to 9% in CY 2025 based on CY 2023 performance.

Key MIPS policy changes include the following:

- MIPS Value Pathways (MVPs). In prior rulemaking, CMS adopted a framework for MVPs that the agency intends as a long-term replacement for the current MIPS. MVPs organize the reporting requirements for each MIPS category around specific medical conditions, clinical specialties or episodes of care. In this rule, CMS adopts five additional MVPs that would be available for the CY 2023 performance period: cancer care, kidney health, episodic neurological conditions, neurodegenerative conditions and promoting wellness. CMS also finalizes modifications to its processes for establishing and scoring MVP “subgroups” within larger physician practices.
- Quality Category. CMS will increase the quality measure data completeness threshold from 70% to 75%, starting with the CY 2024 performance period. In addition, CMS finalizes its proposal to update its definition of high priority measures to include health equity measures, and adds a new health-related social needs screening measure that would be available beginning with the CY 2023 reporting period.

- Promoting Interoperability. Current MIPS policy requires individual clinicians and groups that are part of APM entities to report the Promoting Interoperability category at the individual or group level rather than the APM entity level. However, beginning with CY 2023 reporting, CMS will permit Promoting Interoperability reporting at the APM entity level. In addition, CMS finalizes several changes to the category's objectives and measures for CY 2023 that align with recently adopted changes to the hospital Promoting Interoperability Program. These include modifying the levels of active engagement for the Public Health and Clinical Data Exchange objectives, requiring the reporting of the Query of Prescription Drug Monitoring Program (PDMP) measure, and adding participation in the Trusted Exchange Framework and Common Agreement (TEFCA) to the list of options for satisfying the Health Information Exchange objective.

From an advanced APM perspective, the final rule adopts several policies for which we have advocated, including permanently establishing the 8% minimum General Applicable Nominal Risk standard for advanced APMs.

The final rule also formalizes the proposal to apply the 50 eligible clinician limit for Medical Home Models to the APM Entity participating (as defined by Taxpayer Identification Numbers/National Provider Identifiers on the APM entity's participation list). Per the MACRA statute, certain medical homes can qualify as advanced APMs. Specifically, CMS adopted relaxed financial risk standards for medical homes to qualify as advanced APMs, but limited availability to APM entities owned and operated by organizations with 50 or fewer clinicians.

FURTHER QUESTIONS

If you have further questions, contact Jennifer Holloman, AHA's senior associate director of policy, at jholloman@aha.org.