

**CY 2023 Physician Fee Schedule and Quality Payment Program**  
**Final Rule Summary**

On November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2023 Medicare Physician Payment Schedule (MPS) and Quality Payment Program (QPP) [final rule](#) that impacts payments for physicians and other health care practitioners. CMS had issued a [proposed rule](#) in July, which the AMA responded to with a robust set of [comments](#).

There are a number of policies in the 2023 MPS and QPP final rule that the AMA strongly supports. In addition, there are several policies that the AMA opposes, as well as some policies we think need improvement. Below are some of the highlights from our initial read of the final rule, indicating our support, opposition, or need for improvement.

**Calendar Year 2023 Updates to the Medicare Physician Payment Schedule**

**Conversion Factor and MEI**

The finalized CY 2023 Medicare conversion factor is \$33.06, a decrease of \$1.55 or 4.5 percent from the 2022 CF of \$34.61. The decrease is largely a result of an expiring three percent increase funded by Congress through 2022. The additional approximate 1.6 percent decrease is the result of budget neutrality requirements that stem from the revised E/M changes. The AMA and the Federation are strongly [advocating](#) that Congress avert this payment cut, as well as implement an inflationary update for physicians, extend the five percent Advanced APM incentive and prevent the steep increase to the participation requirements for APMs, and waive the four percent PAYGO sequester.

**Rebasing and Revising the Medicare Economic Index (MEI)**

CMS has finalized the Medicare Economic Index (MEI) weights for the different cost components of the MEI. The current MEI weights are based primarily on results from the AMA’s PPI survey, based on 2006 data. CMS used data from the Census Bureau’s Service Annual Survey (SAS) as the primary source for the new weights. CMS supplemented the SAS data with other sources when SAS does not provide the necessary detail. The changes lead to substantial changes in the weights for many of the key components of physician practice expense. For example, the weight for non-physician compensation increases from 16.6 percent in the current MEI to 24.7 percent in the new MEI, and the weight for professional liability insurance decreases from 4.3 percent to 1.4 percent.

CMS will not implement the MEI changes in 2023, referencing the need for continued public comment due to the significant impact to physician payments. CMS also states that they will be interested to compare the results of the AMA practice expense data collection effort to the data used in their new MEI calculation. The MEI is utilized to proportion the components of the RBRVS between work, practice expense, and professional liability insurance (PLI). The current and proposed proportions of payment would be as follows based on the updated MEI:

RVU Component	Weight	
	Current	New MEI (not implemented)
	<u>2006</u>	<u>2017</u>
Physician Work	50.9%	47.3%
Practice Expense	44.8%	51.3%
Malpractice or PLI	4.3%	1.4%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>

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#### **Geographic Practice Cost Indices**

CMS will update the physician work geographic practice cost indices (GPCIs) in 2023 to reflect 2017-2020 Bureau of Labor Statistics (BLS) Occupational Employment Statistics (OES) wage data. For the 2023 practice expense GPCIs, CMS will utilize the 2015 through 2019 American Community Survey (ACS). The 2023 professional liability insurance (PLI) GPCIs will reflect 2020 premium data gathered by a contractor from state insurer rate filings.

#### **Telehealth**

CMS finalized its proposal to extend telehealth coverage for an additional five months beyond the end of the PHE for the codes that were only going to be on the telehealth list through the end of the PHE.

CMS agreed to maintain the same payment rates for office visits provided in-person or via telehealth through the end of 2023 instead of reducing payments for telehealth visits to the facility rates.

#### **Evaluation and Management (E/M) Visits**

CMS adopted the revised [CPT guidelines and codes](#) and the AMA/Specialty Society RVS Update Committee (RUC) recommended relative values for additional E/M visit code families, including hospital visits, emergency department visits, home visits and nursing facility visits. These changes allow time or medical decision-making to be used to select the E/M visit level.

CMS also finalized creation of Medicare-specific coding for payment of Other E/M prolonged services, similar to what CMS adopted in CY 2021 for payment of Office/Outpatient prolonged services. These services will be reported with three separate Medicare-specific G codes.

#### **Physician Work and Practice Expense (PE) Relative Value Changes**

CMS will implement 80 percent of the AMA/Specialty Society RVS Update Committee's (RUC) work value recommendations and nearly all the RUC's direct practice expenses (PE) cost recommendations for 2023. While CMS will implement the RUC recommendations to increase the valuation of (E/M services and immunization administration, CMS did not fully adopt RUC recommendations for certain other services, including cardiac ablation and hernia repair.

CY 2023 will be the second year of transition for the clinical staff wage rate increases. The warranted recognition of increased wage rates must be budget neutral and, therefore, creates reductions to some physician services, especially those with expensive supplies and equipment.

#### **Professional Liability Insurance Premiums Update**

CMS updated the Professional Liability Insurance (PLI) risk premium data for CY 2023 using more recent data from commercial insurers.

In addition, CMS has collected premium data for all non-physician qualified health care professionals (QHPs), as well as Independent Diagnostic Testing Facility's (IDTF) and clinical laboratories, for the first time, achieving a long-standing RUC recommendation.

#### **Split or Shared Visits**

In response to [advocacy](#) from the AMA and 46 national medical specialty societies, CMS finalized a one-year delay of its policy requiring a physician to see the patient for more than half of the total time of a split or shared E/M visit in order to bill for the service. CMS will continue to allow physicians and qualified health care professionals to use history, physical exam, medical decision making (MDM), or more than half of the total time spent with a patient to determine the substantive portion of the split/shared visit in 2023.

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#### **Dental and Oral Health Services**

The final rule codifies and clarifies in regulation that Medicare payment can be made for the following:

- Reconstruction of a dental ridge performed as a result of and at the same time as the surgical removal of a tumor.
- Stabilization or immobilization of teeth in connection with the reduction of a jaw fracture.
- Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.
- Dental splints only when used in conjunction with medically necessary treatment of a medical condition.

CMS also finalized that dental services (including both examination and treatment) should be covered prior to cardiac valve replacement, valvuloplasty, or organ transplant. CMS finalized that Medicare payment would be provided if these procedures were done on an outpatient or an inpatient basis. CMS also said that ancillary services (such as X-rays, the administration of anesthesia, or the use of an operating room) for these procedures would also be covered.

#### **Behavioral Health Services**

CMS is finalizing the proposal to add an exception to the direct supervision requirement under our “incident to” regulation at 42 CFR 410.26 to allow behavioral health services to be provided under the general supervision of a physician or non-physician practitioner (NPP), rather than under direct supervision, when these services or supplies are furnished by auxiliary personnel.

#### **Chronic Pain Management and Treatment Services**

CMS finalized new HCPCS codes, G3002 and G3003, and valuation for chronic pain management and treatment services (CPM) for CY 2023 and provided some additional flexibilities, such as the ability to report CPM and other visits on the same date and to report subsequent CPM services as many times as needed in a month.

#### **Opioid Treatment Programs (OTPs)**

In order to appropriately price methadone for CY 2023 and subsequent years, CMS is finalizing the proposal to revise its methodology for pricing the drug component of the methadone weekly bundle and the add-on code for take-home supplies of methadone, which will increase the 2023 rate by 5.3 percent.

CMS is also finalizing the proposal to allow the OTP intake add-on code to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with buprenorphine, to the extent that its use of audio-video to initiate treatment with buprenorphine is authorized by the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) at the time the service is furnished. CMS will also allow audio-only technology to be utilized for intake in cases where audio-video is not available to the patient, and CMS will allow audio-only technology for periodic assessments through 2023.

#### **Audiology Services**

CMS finalized a policy to allow beneficiaries direct access to an audiologist without an order from a physician or NPP for non-acute hearing conditions.

#### **Colorectal Cancer Screening**

CMS is finalizing two updates to expand Medicare coverage policies for colorectal cancer screening in order to align with recent United States Preventive Services Task Force and professional society recommendations. First, CMS is expanding Medicare coverage for certain colorectal cancer screening tests by reducing the minimum age payment and coverage limitation from 50 to 45 years. Second, CMS is expanding the regulatory definition of colorectal cancer screening tests to include a complete colorectal

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cancer screening, where a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.

#### **Payment for Preventive Vaccine Administration Services**

CMS finalized its proposals to update the Medicare Part B payment for administration of the influenza, pneumococcal, hepatitis part B, and COVID-19 vaccines based on the annual increases to MEI and to geographically adjust the payments.

#### **Remote Therapeutic Monitoring (RTM)**

Consistent with the AMA's comments, for non-face-to-face RTM services, CMS did not finalize its proposal for four new G-codes, and it agreed to allow for general supervision when physicians and other QHPs use the RTM treatment management services.

#### **Medicare Shared Savings Program (MSSP)**

In an effort to reverse recent trends in the Medicare Shared Savings Program (MSSP), including lack of growth in the number of patients assigned to accountable care organizations (ACOs) and inequitable access to ACOs as shown by data indicating that Black, Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native patients are less likely to be assigned to an ACO than their non-Hispanic White counterparts; CMS finalized substantial changes to MSSP, including:

- Providing advance shared savings payments to low revenue ACOs that are inexperienced with performance-based risk Medicare ACO initiatives and that are new to MSSP (that is, not a renewing ACO or a re-entering ACO).
- Allowing ACOs applying to the program that are inexperienced with performance-based risk to participate in one five-year agreement under a one-sided shared savings model, in order to provide these ACOs more time to invest in infrastructure and redesigned care processes before transitioning to performance-based risk.

#### **Quality Payment Program (QPP) and Merit-Based Incentive Payment System**

##### **Merit-based Incentive Payment System (MIPS) Value Pathways**

CMS finalized five new and seven revised MIPS Value Pathways (MVPs), a new participation option beginning in 2023. The 12 voluntary MVP options for 2023 are:

- Advancing Cancer Care
- Optimal Care for Kidney Health
- Optimal Care for Patients with Episodic Neurological Conditions
- Supportive Care for Neurodegenerative Conditions
- Promoting Wellness
- Advancing Care for Heart Disease
- Optimizing Chronic Disease Management
- Advancing Rheumatology Patient Care
- Improving Care for Lower Extremity Joint Repair
- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
- Patient Safety and Support of Positive Experiences with Anesthesia
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes

In response to AMA's advocacy to make the MVP development and maintenance process more transparent and to ensure that all applicable specialty societies have an opportunity for input, CMS finalized its proposals to provide a 30-day comment period on draft MVP candidates and to host a webinar to solicit feedback on potential revisions to previously finalized MVPs. As CMS implements

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these changes, the AMA will continue to advocate that the agency works collaboratively with the relevant specialty societies in developing and revising MVPs.

#### **Subgroup Reporting**

Subgroup reporting will be an option for MVP participants beginning in 2023. Despite concerns raised by the AMA and other stakeholders, CMS finalized its proposal to require multispecialty groups that choose to report through an MVP to participate as subgroups beginning in 2026. CMS finalized its proposal to limit an individual physician to one subgroup. The agency will score subgroups on population health administrative claims measures and cost measures based on their affiliated group score and, if there is no group score, the administrative claims measures and cost measures would be excluded from the final score. Finally, CMS will not assign a score for subgroups that register but do not submit data for an applicable performance period.

#### **Merit-based Incentive Payment System**

##### *Performance Threshold*

Despite the AMA raising alarms due to CMS' estimate that one-third of MIPS-eligible clinicians would receive a penalty, CMS finalized its proposal to maintain the MIPS performance threshold, which is the minimum score necessary to avoid a penalty, at 75 points. Under MACRA, the \$500 million exception performance bonus expires in payment year 2024, so 2023 will be the first performance period without a corresponding exceptional performance bonus and exceptional performance threshold. In other words, the only bonuses available for 2023 MIPS participants will be budget neutral bonuses resulting from penalties to physicians and groups that score fewer than 75 points.

##### *Quality Performance Category*

CMS is finalizing a total of 198 quality measures for the 2023 performance period. There were four measures that were proposed for removal, but CMS did not finalize them for removal.

Beginning with performance year 2023, CMS will exclusively score administrative claims quality measures against performance period benchmarks. CMS will also expand the definition of a high priority measure to include health equity-related quality measures. CMS also finalized the proposal to increase the data completeness threshold to 75 percent for the 2024 and 2025 performance periods. For the 2023 performance period, the data completeness threshold will remain at 70 percent as finalized in the CY 2022 Physician Fee Schedule Final Rule.\*

Based on AMA and specialty society advocacy, CMS is delaying the requirement for full measure testing, which will now begin with the 2024 performance period. However, CMS is not changing the requirements that QCDR measures be fully tested prior to inclusion in an MVP.

\*Of note, the data completeness threshold policies regarding 70 percent or 75 percent does not apply to CMS Web Interface measures since the CMS Web Interface measures have different data completeness requirements (report on the first 248 consecutively ranked Medicare patients in a sample for a measure or all patients if a sample has less than 248 patients). As a reminder, starting with the 2023 performance period, the CMS Web Interface is only available to Medicare Shared Savings Program Accountable Care Organizations (ACOs) reporting via the APM Performance Pathway (APP).

#### **Promoting Interoperability (PI) Category**

- Query of Prescription Drug Monitoring Program (PDMP) Measure: CMS finalized its proposal to require PDMP query for a minimum of one instance for Schedule II opioid, III, or IV drugs during the 90-day PI performance period. CMS added three exclusions, including one that allows

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a physician for whom querying a PDMP would impose an excessive workflow or cost burden to exclude the required Query of PDMP measure in CY2023.

- Health Information Exchange (HIE) Objective: CMS finalized its proposal to add a new optional measure. Physicians who participate as a signatory to the Trusted Exchange Framework and Common Agreement (TEFCA) and are using certified electronic health record technology to support bi-directional exchange of patient information can attest to TEFCA as an optional measure to meet the HIE Objective.
- Public Health and Clinical Data Exchange objective: CMS finalized its proposal to combine active engagement levels into a single option for a total of two options. Physicians must also submit their level of active engagement. While physicians may spend only one performance period at an engagement level, and then must progress to the Validated Data Production level in the next performance period, required engagement level progression is delayed until CY 2024.

### **Projected 2023 MIPS Participation and 2025 Payment Adjustments**

CMS estimates that 719,516 physicians and qualified health care professionals will be MIPS eligible in the 2023 performance period. The agency projects that about two-thirds of MIPS eligible clinicians who submit some data to CMS would receive a positive or neutral payment adjustment in 2025 based on the 2023 performance period. Many scores are expected to be close to the performance threshold of 75 points, so the number of eligible clinicians who receive bonuses and penalties may differ from these estimates.

Among engaged clinicians, which are those who submit any MIPS data, the average positive payment adjustment is estimated to be 3.71 and the average penalty is estimated to be -1.81. The maximum bonus would be 6.09 percent, and the maximum penalty would be -9 percent. CMS projects that 8.5 percent of eligible clinicians would receive a score of less than 50 points, resulting in a penalty of more than -3 percent.

### **Alternative Payment Models**

Under statute, the five percent incentive payment for QPs expires at the end of the 2022 performance period. In addition, the thresholds to achieve QP status beginning in the 2023 performance period will increase to 75 percent for the payment amount, and 50 percent for patient count. Based on these statutory changes, CMS estimates that between 144,700 and 186,000 eligible clinicians would become QPs in the 2023 performance period, and therefore be excluded from MIPS. This is a reduction from the 271,276 eligible clinicians who earned QP status in 2021. The AMA is strongly urging Congress to extend the five percent APM incentive payment and to continue to allow the Secretary flexibility to set the QP thresholds, including joining the National Association of ACOs and others stakeholders to form the new [Alliance for Value-Based Care](#) to amplify the necessity to continue these policies to support physicians and other providers who are redesigning care and taking on financial risk to improve patient outcomes and curb cost growth.