



AMA's CY 2023 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule Summary

On July 7, 2022, the Centers for Medicare and Medicaid Services (CMS) released the Calendar Year (CY) 2023 Revisions to Payment Policies under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment Policies [proposed rule](#) (Docket number CMS-1770-P). In addition, CMS published a [fact sheet](#) on the PFS proposed rule highlighting the key provisions. If finalized, the proposed policies in the rule will take effect on January 1, 2023. CMS is requesting that **comments be submitted no later than September 6, 2022**. The American Medical Association (AMA) will share a draft comment letter in response to the proposed rule with the Federation in advance of this submission deadline. The AMA is continuing to review the provisions proposed in the rule and will provide further analysis of these policies in the coming weeks.

The proposed rule covers diverse topics, including the CY 2023 Rate Setting and Medicare Conversion Factor, Evaluation/Management (E/M) services, telehealth and other services involving communications technology, and updates to the Quality Payment Program through Merit-based Incentive Payment System (MIPS) activities, methodology, payment adjustments, amongst other provisions. These proposed updates apply to services furnished in all sites by physicians and other practitioners. Below is a summary of select provisions proposed in the rule.

Proposed Payment Policy Provisions

CY 2023 PFS Rate Setting and Medicare Conversion Factor (CF)

CMS proposes a CY 2023 Medicare conversion factor (CF) of \$33.0775, a decrease of \$1.53 or 4.42 percent from the 2022 CF rate of \$34.6062. The proposed CF is largely a result of an expiring 3 percent increase funded to the CF at the end of CY 2022 as required by law. The additional approximate 1.5 percent decrease to the CF is a result of a budget neutrality adjustment primarily from increases to payment for hospital, nursing facility, home health and emergency medicine visits.

Physician Work and Practice Expense (PE) Relative Value Changes

CMS proposes to accept 75 percent of the AMA RVS Update Committee's (RUC) work value recommendations and 85 percent of the RUC's direct practice expenses (PE) cost recommendations. While CMS proposes to accept RUC recommendations to increase the valuation of Evaluation and Management (E/M) services and immunization administration, CMS did decrease the RUC recommendations for several 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 proposes to update the Professional Liability Insurance (PLI) risk premium data for CY 2023 using updated data from commercial insurers. Most physician specialties received small to moderate increases (1 percent - 9 percent) in PLI premium amounts relative to those in place since CY 2020. In addition, CMS has collected premium data for all non-physician qualified healthcare professionals (QHPs), as well as Independent Diagnostic Testing Facility's (IDTF) and clinical laboratories, for the first time, achieving a long-standing RUC recommendation.

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Through CY 2022, when CMS did not have sufficient premium data for a specialty, their practice was to crosswalk the data for those specialties to the data from the physician specialty with the lowest premiums, Allergy & Immunology (2022 premium rate of \$8,874). The RUC has consistently maintained that a risk factor linked to a physician specialty is too high for many of the non-physician QHPs and other non-physician Medicare specialty codes. CMS is now proposing specialty-specific premiums for all non-physician specialties using actual premium data for CY 2023 (with a majority of QHP specialties receiving premium amounts below \$1,000).

For CY 2023, CMS is projecting PLI RVU changes alone to reduce radiology's overall allowed charges by 2 percent and radiation oncology's overall allowed charges by 1 percent, which contrasts with radiology's and radiation oncology's PLI risk premiums increasing by 9 percent for CY 2023. The RUC has identified a technical error causing a \$110 million PLI RVU reduction for all codes with the professional component/technical component split and will alert CMS of the issue.

Request for Information on Strategies for Updates to Practice Expense (PE) Data Collection and Methodology

CMS currently utilizes data from the AMA's Physician Practice Information (PPI) Survey in determining PE relative values. This survey, last conducted in 2007-2008, collected 2006 data. CMS calls for comment on strategies to update these cost data. The AMA convened meetings with CMS to discuss AMA's 2020 practice expense survey pilot which focused on smaller practices and to share information on ongoing efforts. AMA is currently working with Mathematica to develop a proposal and methodology for a 2023 survey effort which would collect 2022 data. Simultaneously, the AMA has convened interviews with 20 health systems and large physician practices which will, along with the learnings from the 2020 pilot, inform the development of this methodology.

Rebasing and Revising the Medicare Economic Index (MEI)

CMS is proposing to revise 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 is proposing to use data from the Census Bureau's Service Annual Survey (SAS) as the primary source for the new weights. They propose to supplement the SAS data with other sources when SAS does not provide the necessary detail. The proposed 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 proposed 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 public comment due to the significant impact to physician payments. 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 2006	Proposed 2017
Physician Work	50.9%	47.3%
Practice Expense	44.8%	51.3%
Malpractice or PLI	4.3%	1.4%
Total	100.0%	100.0%

The impact of this change would harm physician specialties that have higher work relative values and/or lower practice costs with significant overall Medicare payment reductions (cardiothoracic surgery (-9 percent), neurosurgery (-8 percent), emergency medicine (-7 percent), anesthesiology (-6 percent)), while providing increases to specialties or entities that incur significant practice expense (diagnostic testing facilities (+16 percent), portable x-ray supplier (+15 percent), independent laboratory (+10 percent), radiation therapy centers (+6 percent)).

Geographic Practice Cost Indices

CMS proposes to 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 proposes to 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. CMS also proposes to reduce the number of distinct localities in California from 32 to 29. CMS also proposes several methodological changes to the computation of GPCIs, including modifications to occupations used as proxies from the BLS OES data and weighting changes to the geographic adjustment factor (GAF). Finally, CMS extensively discusses and defends the current use of county-level residential rent data as a proxy for relative cost differences in physician office expense.

Comment Solicitation on Global Surgical Services

CMS continues to speculate that the visits captured within the global surgical payment are not typically performed, supported by analysis conducted by the RAND Corporation. In preparation for future rulemaking, CMS requests comment on numerous questions to determine the relevancy of the surgical global periods and the typicality of surgical post-operative visits. Comments are also requested on the strategy to evaluate individual physician services, including: “(1) revaluing all 10- and 90-day global packages at one time (perhaps with staggered implementation dates); (2) revaluing only the 10-day global packages (because these appear to have the lowest rate of postoperative visit performance, per RAND’s analysis of claims data); (3) revaluing 10-day global packages and some 90-day global packages (such as those with demonstrated low postoperative visit performance rates as identified in RAND’s analysis of these services); or (4) relying on the Potentially Misvalued Code process to identify and revalue misvalued global packages over the course of many years.” The RUC’s potentially misvalue code process uses objective screens to identify services with anomalous global periods or visits used within the valuation.

Evaluation and Management (E/M) Visits

Following groundbreaking revisions in 2021 to office and outpatient E/M visits as recommended by the CPT Editorial Panel and the RUC, which allow physicians to select the E/M visit level to bill based on either total time spent on the date of patient encounter or the medical decision making utilized in the provision of the visit, CMS is proposing similar revisions to other E/M visit code sets, including inpatient and observation visits, emergency department (ED) visits, nursing facility visits, domiciliary or rest home visits, home visits, and cognitive impairment assessment. Specifically, CMS is proposing to generally adopt the revised [CPT E/M Guidelines](#) for these E/M visits and valuations as recommended by the RUC. These changes allow time or medical decision-making to be used to select the E/M visit level. History and physical exam would be considered, as medically appropriate, and would no longer be used to select visit level. Additional changes include deletion of observation CPT codes, which would be merged into the existing hospital care CPT code set. CMS also proposes Medicare-specific coding for prolonged services, which is consistent with CMS’ previously finalized approach to prolonged office and outpatient E/M services.

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In total, the E/M code sets being revised for 2023 comprise approximately 20 percent of all allowed charges under the Medicare Physician Payment Schedule. Therefore, these changes are estimated to require a reduction of about 1.5 percent to the 2023 Medicare conversion factor due to statutory budget neutrality requirements.

Split (or Shared) E/M Visits

In response to [advocacy](#) from the American Medical Association (AMA) and 46 national medical specialty societies, CMS proposes 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. A split or shared visit refers to an E/M visit performed by both a physician and a qualified health care professional (QHP) in the same group practice in the facility setting where “incident to” billing is not available. Longstanding CMS policy has been that the physician can bill for a split or shared visit if they perform a substantive portion of the encounter. Medicare pays physicians at 100 percent of the Physician Payment Schedule rate, while QHPs are paid at 85 percent of the Physician Payment Schedule. Through calendar year 2023, physicians would continue to bill split or shared visits based on the current definition of substantive portion as one of the following: history, exam, medical decision-making, or more than half of total time.

We are glad that CMS heard our concerns that the time-based definition of substantive portion would drastically disrupt team-based care and interfere with the way care is delivered in the facility setting as it does not account for medical decision-making by the physician. The AMA will work with the national medical specialty societies to develop consensus-based alternative proposal to billing split or shared visits based on whether the physician spends more than half of the total time with the patient.

Electronic Prescribing of Controlled Substances (EPCS)

In the 2022 Medicare payment final rule, CMS established a number of EPCS policies. With several exceptions, for example, for physicians who prescribe fewer than 100 Part D prescriptions annually, physicians were required to electronically prescribe Medicare Part D controlled substances in 2022 with compliance enforcement starting in 2023. For the first year of enforcement, compliance will consist of a letter being sent to the physician and urging them to adopt EPCS. In this rule, CMS proposes to extend the enforcement policy of sending a letter to the physician through the second year of enforcement, 2024. CMS seeks comments on additional actions that it could take in the future to enforce compliance with the EPCS requirement, but without having an “unintended consequence of incentivizing prescribers to stop prescribing controlled substances to Part D beneficiaries, where appropriate, should they not have EPCS set-up.” CMS also proposes to adjust timelines for the EPCS requirement to align its actions with the availability of data as, for example, the agency cannot ascertain if a physician has prescribed fewer than 100 Part D controlled substance prescriptions until after the year has ended.

Telehealth and Other Services Involving Communications Technology

During the COVID-19 Public Health Emergency (PHE), CMS significantly expanded the Medicare Telehealth List through the addition of about 150 services that can now be provided via telehealth, including emergency department visits, critical care, home visits, and telephone visits. It also created two new categories of interim telehealth services. Codes in Category 3 of the Medicare Telehealth List are covered on an interim basis until data can be gathered to help determine whether they should become Category 1 or 2 services or be removed from telehealth coverage. Category 3 services will be covered through the end of 2023. Interim services that are not in Category 3 were only slated to be covered until the end of the PHE. In March 2022, the Consolidated Appropriations Act included a provision that extended payment for Medicare telehealth services to all communities in the country, not just rural areas, and allowed patients to continue to receive telehealth services in their homes or wherever they are located without going to a medical facility for an additional 151 days after the end of PHE, which is five months. In this proposed rule, CMS proposes to similarly extend Medicare telehealth coverage for the codes that

were only going to be on the telehealth list through the end of the PHE for an additional five months after the PHE ends.

In response to an AMA recommendation that the three CPT codes for telephone visits be added to Category 3 and be covered on an interim basis through 2023, CMS indicates in this rule that it decided not to add the telephone visit codes to Category 3. CMS clarifies, however, that since the telephone visit codes are among those slated to be removed from telehealth coverage when the PHE ends, they will now be covered for an additional five months after the PHE ends like the other services subject to this new policy. CMS also raises concerns about the statutory authority to extend telehealth coverage for these services, noting that the agency believes the statute requires telehealth services be so analogous to in-person care such that the telehealth service is a substitute for a face-to-face encounter, but that the audio-only CPT codes are inherently non-face-to-face. CMS does propose to add a number of other services, including therapy services, ophthalmology services, and patient education and training in self-measured blood pressure management, to Category 3, so these codes will continue to be available via telehealth through 2023.

CMS is also proposing certain changes in coding and payment policies that would take effect five months after the PHE ends. Most importantly, Medicare telehealth services would revert to being paid at the “facility” rate instead of the “non-facility” rate, as CMS believes that the facility payment amount “best reflects the practice expenses, both direct and indirect, involved in furnishing services via telehealth.”

Request for Information: Medicare Potentially Underutilized Services

CMS is inviting stakeholder feedback and soliciting comment regarding ways to identify and improve access to high value, potentially underutilized services by Medicare beneficiaries. CMS is also seeking comments on ways to recognize possible barriers to improved access to high value services and how they might best mitigate some of the obstacles to care.

The Agency is inviting the public to submit information about specific obstacles to accessing these services and how specific potential policy, payment, or procedural changes could reduce potential obstacles and facilitate better access to high value health services. Specifically, they are soliciting new and innovative ideas that may help broaden perspectives about potential solutions. Ideas may include, but are not limited to:

- Educational or marketing strategies (informed by beneficiary input) to promote awareness of available programs and resources that advance the utilization of “high value” services;
- Aligning of Medicare and other payer coding, payment and documentation requirements, and processes related to “high value” services;
- Recommendations from States and other interested parties regarding how to best raise awareness of underutilized services, with special consideration for the dual-eligible population;
- Enabling of operational flexibility, feedback mechanisms, and data sharing that would enhance the utilization of “high value” services; and
- New recommendations regarding when and how CMS issues regulations and policies related to “high value” services and how CMS can advance rules and policies for beneficiaries, clinicians, and providers.

CMS is interested in learning about how they might best promote high value care and health equity, address concerns regarding health disparities, and increase access to high value services, which could improve the health of Medicare beneficiaries. Comments received in response to this RFI may be used to identify potential opportunities for improvement to and refinement of existing Medicare FFS and MA programs.

Behavioral Health Services

In an effort to ensure that behavioral health practitioners across the country can practice to the full extent of their license CMS is proposing to allow licensed professional counselors (LPCs), marriage and family therapists (LMFTs), and other types of behavioral health practitioners to provide behavioral health services under general supervision instead of direct supervision. CMS is also proposing to pay for clinical psychologists and licensed clinical social workers to provide integrated behavioral health services as part of a patient's primary care team.

Opioid Treatment Programs (OTPs)

CMS is proposing to increase payment rates to Opioid Treatment Programs in order to better reflect the costs of the counseling services, while also proposing to pay for the initiation of buprenorphine (which treats opioid use disorder) over telehealth, rather than just in person, to further improve access. CMS also proposes to clarify that OTPs can bill Medicare for medically reasonable and necessary services provided in mobile units to increase access to individuals affected by homelessness and living in rural areas.

Chronic Pain Management

The 2022 Medicare payment rule included a discussion of potential new policies for physicians treating patients with chronic pain, with CMS indicating that it would consider the comments it received in future rulemaking. CMS is now proposing a new monthly bundled payment for management of patients with chronic pain, identified as codes GYYY1 and GYYY2. The first of these codes is defined as:

Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care (e.g. physical therapy and occupational therapy, and community-based care), as appropriate. Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month.

The second code would apply to up to three units of an additional 15 minutes of chronic pain management per month. CMS proposes to define chronic pain as pain lasting more than three months.

Immunization Administration and Payment for Preventive Vaccine Administration Services

CMS proposes to adopt the RUC's recommended work RVUs and direct PE inputs (with minor refinements) for vaccine administration services (CPT codes 90460, 90461, 90471, 90472, 90473, and 90474).

Specific to the administration of influenza, pneumococcal, and HBV vaccines, CMS established a payment amount of \$30, effective Jan. 1, 2022. CMS proposes to geographically adjust preventive vaccine administration services. To account for the change in costs of administering preventive vaccines,

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CMS also proposes to update the payment amount (that is, \$30) based upon the annual increase to the MEI. These adjustments would apply to HCPCS codes G0008, G0009, and G0010.

Also, effective January 1 of the year following the year in which the PHE ends, the \$40 payment rate for administration of the COVID-19 vaccines will be adjusted to align with the payment rate for the administration of other Part B preventive vaccines. CMS proposes to geographically adjust and update the COVID-19 vaccine administration codes based on MEI. For example, if the COVID-19 PHE ends in CY 2022, the payment amount for COVID-19 vaccine administration would change from \$40 to \$30 effective January 1, 2023, and CMS would apply the proposed geographic adjustments and the proposed MEI annual update.

CMS also proposes to continue the additional payment of \$35.50 when a COVID-19 vaccine is administered in a beneficiary's home under the certain circumstances through 2023. CMS proposes to geographically adjust and apply the MEI update to the \$35.50 add-on payment. The agency seeks comments about expanding the add-on payment for in-home administration to other preventive vaccines.

Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers

CMS proposes to expand Medicare coverage of certain colorectal cancer screening tests by reducing the minimum age payment limitation from 50 to 45 years, consistent with a recently revised recommendation by the United States Preventive Services Task Force (USPSTF). The agency would also expand the definition of colorectal cancer screening tests to include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based screening test returns a positive result. Therefore, beneficiary care sharing for the initial stool-based test and the follow-up screening colonoscopy test would not apply and both tests would be paid at 100 percent of the Physician Payment Schedule as screening services.

Proposals and Request for Information on Medicare Parts A and B Payment for Dental Services

CMS generally does not cover dental services under Medicare Parts A or B, unless there is an inpatient hospital service for an underlying medical condition that necessitates dental services or the severity of the dental procedure requires hospitalization. Based on feedback CMS has received that their interpretation of section 1862(a)(12) is unnecessarily restrictive, contributes to inequitable distribution of dental services to Medicare beneficiaries, and in some instances, dental services are related to clinical success of covered Medicare Part A and Part B medical services, CMS has six points for public comment on dental services. First, CMS proposes to clarify and codify its policies for Medicare FFS for medically necessary dental services. CMS is interested in receiving public comments on what professional services, including, but not limited to dental services, may occur during and prior to the patient's hospitalization or procedure requiring hospitalization under this exception. CMS may consider finalizing additional payment policies in this area. Next, CMS proposes payment for other dental services performed as a comprehensive workup prior to certain medical services: organ transplant surgery, cardiac valve replacement or valvuloplasty procedures. CMS proposes to pay for these comprehensive workup dental services before certain medical services either on an inpatient or outpatient basis, and proposes to include services that are ancillary to these dental services, such as x-rays, administration of anesthesia, use of an operating room, other facility services. Whereas the National Coverage Determinations (NCD) Manual does not recognize a dentist as a physician under section 1861(r), CMS now considers this interpretation unnecessarily narrow, and proposes to cover and pay under Medicare Part B for dental services prior to certain medical services when performed by a doctor of dental surgery or dental medicine, as defined in section 1861(r)(2).

While CMS has proposed this limited list of procedures, it is also requesting comments on other types of clinical scenarios where dental services may be inextricably linked, substantially related, and integral to the clinical success of other covered medical services. CMS also requests comment on other potentially impacted policies, and finally, CMS requests comment on potential future payment models for dental and

oral health services. CMS proposes to continue to contractor price dental services for CY 2023 or until it has further data to establish prospective payment rates. CMS is also interested on whether there are clinical circumstances under which Medicare payment could be made for dental services furnished after a covered medical procedure or treatment. CMS seeks medical evidence that the provision of certain dental services leads to improved healing, improved quality of surgery, and the reduced likelihood of readmission and/or surgical revisions. CMS seeks comments on how to integrate the payment for dental and oral health care services under CMMI's waiver authority in existing or future service delivery models, including models focused on equity, care coordination, total cost of care and specific disease conditions.

Skin Substitutes/Wound Care Management Products

CMS is interested in consistent coverage, coding and payment for skin substitute products across the physician office and hospital outpatient department settings. The agency is proposing to change the terminology of skin substitutes to wound care management products to reflect how clinicians use these products and to pay for these products as incident to supplies under the physician payment schedule beginning on Jan. 1, 2024. Under CMS' proposal, in the office setting, CMS would no longer pay separately for skin substitute products under the ASP+6 percent methodology. Instead, CMS would include the cost of these products as resource inputs in establishing practice expense RVUs for associated physician's services effective Jan. 1, 2024.

The AMA has received clarification from CMS that for 2023, these products would be contractor priced and billed separately from the procedure to apply them. The Medicare Administrative Contractors (MACs) set the payment rates in their jurisdictions. In order to establish national payment rates for provision of these products, CMS would go through future notice and comment rulemaking.

Audiology Services and Waiver of Physician Order

CMS proposes to remove the physician order requirement under certain circumstances for certain audiology services furnished personally by an audiologist for non-acute hearing conditions. These non-acute hearing conditions would not include balance assessments that are used for patients with disequilibrium. This is because CMS believes the physician/NPP needs first to evaluate the patient clinically due to the many serious medical conditions the beneficiary might have, and ensure the patient is cleared medically before setting them on track to receive vestibular function tests, possibly from an audiologist. CMS also proposes the addition of a HCPCS code, GAUDX, to describe the tentative list of audiology services furnished by an audiologist without the order of the treating physician or practitioner. For this proposal, CMS is requesting comments on how and where these audiology services would be provided without the order of a treating physician or practitioner.

Medicare Shared Savings Program (MSSP)

CMS acknowledges that in recent years, growth in the number of patients assigned to Shared Savings Program accountable care organizations (ACOs) has plateaued; higher spending populations are increasingly underrepresented in the program since the change to regionally-adjusted benchmarks; and access to ACOs appears inequitable as show 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. In an effort to reverse these trends, CMS is proposing substantial changes to MSSP, including:

- Providing advance shared savings payments to low revenue ACOs that are inexperienced with performance-based risk Medicare ACO initiatives, that are new to the Shared Savings Program (that is, not a renewing ACO or a re-entering ACO), and that serve underserved populations.

Advance investment payments would include a one-time fixed payment of \$250,000 and quarterly payments for the first 2 years of an ACO's 5-year agreement period.

- Allowing ACOs applying to the program that are inexperienced with performance-based risk to participate in one 5-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 for high quality and efficient health care service delivery before transitioning to performance-based risk.
- Establishing a health equity adjustment of up to 10 bonus points that would upwardly adjust an ACO's quality performance score, to reward ACOs that report all-payer eCQMs/MIPS CQMs, that are high performing on quality, and serve a high proportion of underserved beneficiaries
- Extending the incentive for reporting eCQMs/MIPS CQMs through performance year 2024 to align with the sunset of the CMS Web Interface reporting option.
- Revising benchmarking policies to incorporate a prospectively projected administrative growth factor; adjust benchmarks to account for prior savings; and reduce the impact of negative regional adjustments on ACO benchmarks by reducing the cap on negative regional adjustments and gradually decreasing the negative regional adjustment amount as an ACO's weighted-average prospective HCC risk score increases, or the proportion of dually eligible Medicare and Medicaid beneficiaries increases, or both.

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

The Centers for Medicare and Medicaid Services is proposing several updates to the Quality Payment Program and Medicare Shared Saving Program for 2023. It also includes a timeline for implementation of the new voluntary Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs).

MIPS Value Pathways (MVPs)

CMS is moving ahead with a voluntary MVP participation option starting in 2023 and proposing five new MVPs, including:

- Advancing Cancer Care,
- Optimal Care for Kidney Health,
- Optimal Care for Neurological Conditions,
- Supportive Care for Cognitive-Based Neurological Conditions, and
- Promoting Wellness.

CMS is also proposing revisions to the seven MVPs that were finalized in the 2022 Medicare physician payment final rule due to the proposed removals of certain activities from the improvement activities inventory and the addition of other relevant existing quality measures for MVP participants to select from. There would be a total of 12 optional MVPs for physicians to choose from in 2023. Although MVPs have the potential to make participation less burdensome and more clinically relevant, CMS continues to apply faulty Traditional MIPS requirements to MVPs and has yet to adopt AMA recommendations, such as multi-category credit.

In response to AMA advocacy calling for greater transparency and inclusion of all applicable specialty societies in development of MVPs, CMS is also proposing to add more opportunities for public comment during the MVP development process. First, prior to proposing an MVP in rulemaking, CMS will post near-final MVPs on the QPP website and solicit feedback from interested parties for a 30-day period. Note, however, that if CMS determines changes are appropriate, the agency proposes not to notify the specialty society or other stakeholder that initially submitted the candidate MVP prior to rulemaking. Second, CMS proposes to solicit recommendations for potential updates to established MVPs on an annual basis. CMS would host an annual webinar to go over the feedback on potential revisions to the MVPs.

CMS seeks comment about aligning MVPs and APM reporting requirements, how to ensure that MVP reporting serves as a bridge to APM participation, and how to reduce burden for APM participants in multispecialty groups who choose to participate in MVPs, including whether the agency should develop a process for a composite score that incorporates both APP measures and other MVP specialty measures.

Subgroup Reporting

Subgroup reporting will be an option for MVP participants beginning in 2023. CMS would require multispecialty groups that choose to report through an MVP to participate as subgroups beginning in 2026. CMS proposes to limit an individual physician to one subgroup. The agency would 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 would not assign a score for subgroups that register but do not submit data for an applicable performance period.

Merit-based Incentive Payment System (MIPS)

Performance Threshold

CMS proposes 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.

Cost Performance Category

Under statute, the weight of the Cost Performance Category will continue to be 30 percent of the final MIPS score. CMS proposes to change the designation of the Medicare Spending Per Beneficiary (MSPB) Clinician cost measure to a care episode group. Finally, CMS proposes to establish a maximum cost improvement score of 1 point out of 100 percentage points available for the cost performance category starting in the 2022 performance period, which corresponds to the 2024 payment year.

CY 2023 MIPS Promoting Interoperability

Public Health and Clinical Data Exchange Objective

CMS is proposing to modify the levels of active engagement for the required Public Health and Clinical Data Exchange Objective measures. CMS is proposing to reduce the number of active engagement options from three down to two. In addition to requiring a yes/no response for the Public Health and Clinical Data Exchange measures, CMS is also proposing to require physicians to submit their level of active engagement.

Query of Prescription Drug Monitoring Program (PDMP) measure

CMS is proposing to make this a required measure beginning with the 2023 performance period. CMS is proposing to add exclusions for the measure and make it worth 10 points. CMS is also proposing to expand the scope of the measure to include not only Schedule II opioids but also Schedules III and IV drugs.

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Health Information Exchange (HIE) Objective

CMS is proposing a third option for satisfying the HIE objective for the 2023 performance period, in addition to the two existing options. Proposed Option 3: Participation in the Trusted Exchange Framework and Common Agreement (TEFCA).

Physician Compare/Public Reporting

CMS proposes to publicly report a telehealth indicator for those clinicians furnishing covered telehealth services and utilization data.

CY 2023 Request for Information (RFI)

Advancing the Trusted Exchange Framework and Common Agreement (TEFCA) RFI

CMS is requesting input on opportunities to incentivize participation in TEFCA through programs that incentivize high quality care, or through program features in value-based payment models that encourage certain activities that can improve care delivery.

Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in the Quality Payment Program RFI

CMS is requesting input on the topics of (a) data standardization activities related to leveraging and advancing standards for digital data, and (b) transitioning to FHIR electronic clinical quality measure (eCQM) reporting, as initial steps in CMS' transition to digital quality measurement.

CMS also includes requests for information on/;

- The potential addition of questions on healthcare disparities and price transparency to the CAHPS for MIPS Survey,
- Whether a shortened version of the CAHPS for MIPS Survey could be created to make it more broadly applicable to specialty groups,
- The development and implementation of health equity quality measures and quality measures that address amputation avoidance in diabetic patients and
- CMS also includes a request for information on ways to incorporate health equity into public reporting on Care Compare.

Projected 2023 MIPS Participation and 2025 Payment Adjustments

CMS estimates that 865,116 physicians and qualified health care professionals will be MIPS eligible in the 2023 performance period. The agency projects that 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. However, the agency admits that 80 percent of those who do not submit any data and as a result may be subject to a penalty of up to 9 percent are clinicians in small practices. Approximately 16,614 out of 20,810 clinicians who do not engage are in small practices.

The average positive payment adjustment is estimated to be 2.49 percent and the average penalty is estimated to be -1.64 percent. The maximum bonus would be 6.9 percent, and the maximum penalty would be 9 percent. CMS projects that about 7 percent of clinicians would receive a score of less than 50 points, resulting in a penalty of more than 3 percent.

Alternative Payment Models (APMs)

CMS is proposing to introduce a voluntary option for APM Entities to report the Promoting Interoperability performance category at the APM Entity level. The agency is clarifying that the criterion for Advanced APMs that payment must be based on quality measures can be met using a single quality measure. CMS would permanently establish the generally applicable revenue-based nominal amount standard at 8 percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers in participating APM Entities for the applicable QP performance period, beginning in 2023. In addition, the agency proposes to apply the Medical Home Model 50 eligible clinician limit to the APM Entity, not the parent organization for the APM Entity.

CMS is also requesting comments on (1) Qualifying APM Participant (QP) determination calculations at the individual eligible clinician level and (2) the gap in statutory financial incentives for QPs in the 2025 payment year after the APM bonus expires but before the 0.75 update to the conversion factor begins in 2026, and the difference in financial incentives between QPs and MIPS eligible clinicians beginning in 2026.

Under statute, the 5 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.