Policy Update

CMS Finalizes CY 2023 Physician Fee Schedule Rule

On November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) released the CY 2023 Revisions to Payment Policies Under the Physician Fee Schedule (PFS) and Other Revisions to Medicare Part B [CMS-1770] Final Rule, which includes final policies related to Medicare physician payment and the Quality Payment Program (QPP).

The final rule establishes a 4.47% cut to physician payments under the 2023 fee schedule unless Congress can pass legislation that would offset or mitigate this reduction in payment. Stakeholders had hoped for an improvement over the proposed rule's 4.42% reduction to the conversion factor (CF), but the final rule's methodology resulted in a slight decrease. Physicians are concerned that full relief may not be possible given the significant cost of offsetting an almost 4.5% cut and the many competing interests facing Congress in an end-of-year legislative package.

The final rule includes other significant changes, including changes related to accountable care organizations (ACOs), the launch of the Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs), telehealth services, initiatives promoting access to behavioral health services, and other changes to further develop physician quality initiatives.

Key Takeaways from the CY 2023 PFS Final Rule:

- Finalizes a 2023 physician CF of $33.0607, representing a 4.47% reduction from the 2022 CF of $34.6062
- Implements the statutory extension of coverage for certain telehealth services to 151 days after the end of the public health emergency (PHE)
- Begins the new MVPs as a voluntary alternative to MIPS in 2023 with 12 different pathways
- Finalizes changes to the Medicare Shared Savings Program (MSSP) and introduces new advance investment payments intended to achieve the Administration's goal of 100% participation in accountable care relationships by 2030
- Outlines policies to make behavioral health care easier to access, including addressing the shortage of behavioral health practitioners

Read on for a topline summary of the major provisions in the final rule.

- Final rule text
- CMS press release
- CMS fact sheet
- CMS fact sheet on the MSSP finalized changes
- CMS blog on the finalized behavioral health changes

Major PFS Payment Proposals

Conversion Factor

Medicare physician payment is based on application of a dollar-based CF to geographically adjusted work, practice expense (PE) and malpractice relative value units (RVUs). Work RVUs capture the time, intensity and risk of the provider. PE RVUs capture the cost of supplies, equipment and clinical personnel wages used to furnish a specific service. Malpractice RVUs capture the cost of malpractice insurance.

Key Takeaway: The CY 2023 CF decreased to $33.0607, a reduction of 4.47%.

Medicare Physician Conversion Factor (2017–2023)		
Year	**CF**	**Actual Update (%)**
Jan 1, 2017	35.8887	0.24
Jan 1, 2018	35.9996	0.31
Jan 1, 2019	36.0391	0.11
Jan 1, 2020	36.0896	0.14
Jan 1, 2021	34.8931	-3.32
Jan 1, 2022	34.6062	-0.82
Jan 1, 2023	**33.0607**	**-4.47**

The 2023 final physician CF is **$33.0607**. This represents a decrease of **4.47%** from the 2022 CF of $34.6062. The 2023 anesthesia CF is **$20.6097**, which represents an approximately **4.42% reduction** from the 2022 anesthesia CF of $21.5623.

The update is based on several factors: a statutory 0% update scheduled for the PFS in CY 2023[1] and a funding patch passed by Congress at the end of CY 2021 through the Protecting Medicare and American Farmers from Sequester Cuts Act. This bipartisan legislation partially mitigated a 3.75% cut to the CY 2022 CF and staved off other Medicare cuts, including a phased-in delay of the Medicare sequestration and pay-as-you-go cuts. The 3% payment patch was only in effect for 2022, and the Medicare sequestration relief was phased out starting April 1, 2022. The overall negative adjustment to the CF for 2023 is driven by the expiration of the 3% payment patch and a statutorily required budget neutrality adjustment due to other spending increases. Additionally, unless Congress acts to further delay anticipated cuts arising from pay-as-you go federal budget requirements, Medicare payments could be cut by an additional 4%.

These payment reductions come at a time when physician practices, hospitals that employ physicians and other stakeholders are facing uncertainty about the future of their pandemic recovery (including the duration of the PHE), rising costs due to inflation, staffing shortages and significant challenges from other regulatory burdens (*e.g.*, prior authorization, interoperability requirements and participation in Medicare quality programs such as MIPS). In light of these burdens, the provider community will continue to press Congress for relief, although it is unclear whether lawmakers will be able to fully offset all of the anticipated payment reductions. Further congressional action for 2022 is possible, setting up a potential end-of-year Medicare package during a lame duck session in December.

[1] The Medicare Access and CHIP Reauthorization Act of 2015 established a 0% update for PFS services through 2025. Beginning in 2026, clinicians identified as qualified participants in an Advanced Alternative Payment Model will receive an annual 0.75% update, and all other clinicians will receive a 0.25% annual update.

Specialty Impact

Key Takeaway: The impact by specialty will range from -3% to +7%.

Actual payment rates are affected by a range of policy changes related to physician work, PE and malpractice RVUs. While the impact on individual practices will vary based on service mix, Table 148 in the final rule provides insight into the rule's policies for a specific specialty. Specialty impacts range from -3% for interventional radiology and vascular surgery, to +7% for diagnostic testing facilities. Importantly, changes to the CF are not reflected in the impact table.

While some of the differences result from finalized changes to individual procedures, the continued clinical labor pricing transition is anticipated to significantly decrease payments for specialties with lower average shares of direct costs attributable to labor. The second-year transition of this policy, which impacts PE RVUs, likely drives the negative impact for radiology and interventional radiology, vascular surgery and nuclear medicine, summarized in the table below. Specialties with substantially higher average shares of direct costs attributable to labor are anticipated to see significant increases in payment from the second-year transition. Specialties anticipated to benefit from finalized policies include infectious disease, geriatrics and internal medicine.

Impact of Finalized Changes by Selected Specialties

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of Malpractice RVU Changes	Combined Impact
Infectious Disease	$590	4%	0%	0%	4%
Geriatrics	$177	2%	0%	0%	2%
Internal Medicine	$9,881	2%	0%	0%	3%
Nuclear Medicine	$54	-1%	-1%	0%	-2%
Radiology	$4,734	-1%	-1%	0%	-2%
Vascular Surgery	$1,104	0%	-3%	0%	-3%
Interventional Radiology	$467	-1%	-3%	0%	-3%

**Note: Combined impact may not equal the sum of work, PE and malpractice as a result of rounding. Source: Table 148, CY 2023 PFS, display copy*

This year, CMS provided an additional table that includes a facility/non-facility payment breakout of changes for each specialty (Table 149).

In the 2023 proposed rule, CMS sought public comment on strategies to improve global surgical package valuation to support future rulemaking. Any change in the global period policy could impact specialties differently. Global surgical packages include the surgical procedure and services provided during pre- and postoperative visits. In the 2015 Medicare PFS final rule, CMS finalized a policy to transition all services with a 10-day and 90-day global period to 0-day global periods. Implementation of this policy was halted by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, which required CMS to collect additional data on how best to value global packages. CMS has stated that it "continue[s] to be concerned that our current global packages reflect certain [evaluation and management](E/M) visits that are not typically furnished in the global period, and thus, are not occurring."

In the final rule, CMS noted that it did not receive new data to either affirm or contradict previous findings regarding E/M performance. CMS continues to call into question the accuracy of valuations of global packages, but notes that currently there is no clear public consensus on this issue or the preferred strategy for valuing global packages. CMS welcomes additional feedback from interested parties as it considers appropriate next steps.

Practice Expense

Key Takeaway: CMS will likely address indirect PEs in future rulemaking.

Beginning in 2019, CMS updated the supplies and equipment prices used for calculating PEs, which were implemented through a four-year transition that was finalized in 2022. Last year, CMS finalized a proposal to update prices for clinical labor through a four-year transition period that will be completed in 2025. Physician specialties with substantially higher average shares of direct costs attributable to clinical labor are anticipated to see increases in payment from the clinical labor pricing update, while those with lower average shares of direct costs attributable to labor are anticipated to see decreases in payment. During the four-year transition period, clinical labor rates will remain open for public comment.

For CY 2023, CMS finalized an update in the pricing for five clinical labor types (Lab Tech/Histotechnologist (L035A), Histotechnologist (L037B), Vascular Interventional Technologist (L041A), Mammography Technologist (L043A) and CT Technologist (L046A)) based on additional data submitted by commenters.

Although CMS did not propose a methodology for updating future PEs, CMS believes "it is necessary to establish a roadmap toward more routine PE updates." CMS also believes that indirect PEs would benefit from a data refresh, and signaled "[its] intent to move to a standardized and routine approach" to valuing indirect PEs. CMS noted that it received few direct responses to many of the specific prompts included in its request for information. Most commenters recommended that CMS delay any changes to update the indirect PE survey inputs and urged CMS to wait for the American Medical Association (AMA) data collection effort prior to implementing any changes. The AMA indicated that it has continued to work on updates and will likely be ready by early CY 2024 with refreshed data. CMS acknowledged comments that refreshed survey data alone would not address all the competing concerns that CMS must account for when allocating indirect expenses, and noted that the agency may look to supplement or augment survey data with other verifiable, objective data sets in the future, including data sets that are already in the public domain.

CMS also made several changes to direct and indirect PE inputs for specific services, including for international normalized ratio services and remote musculoskeletal therapy systems.

Rebasing and Revising the Medicare Economic Index

Key Takeaway: CMS finalized a new methodology for updating the Medicare Economic Index (MEI) for future years.

The MEI measures the input price pressures of providing physician services, looking at physicians' own time (compensation) and physicians' PE. While the MEI is no longer directly used in calculating the annual update to the PFS CF, it continues to be used for the Medicare telehealth originating site facility fee, targeted medical review threshold amounts, rural health clinic payment limits, geographic practice cost index and other policies. The current MEI relies on 2006 data for self-employed physicians and may not account for current costs and market changes.

In the proposed rule, CMS offered a new methodology to both rebase and revise the MEI that relies on publicly available data. CMS believes that this change would allow for the use of data that are more reflective of current market conditions of physician ownership practices, rather than only reflecting costs for self-employed physicians, and would allow the MEI to be updated on a more regular basis.

In this rule, CMS largely finalized its proposal with some technical changes based on comments received. CMS noted that using the proposed new MEI cost weights to set PFS rates should not change overall spending on PFS services but would likely result in significant changes to payments among PFS services. Accordingly, the agency will not use the updated MEI cost share weights to set payments for CY 2023 but may do so in future years.

Split (or Shared) Services

Key Takeaway: CMS delayed implementing "substantive portion" definition until January 1, 2024.

In the CY 2022 PFS final rule, CMS finalized a policy allowing reimbursement to a physician or non-physician practitioner for shared (or split) visits when the billing practitioner performs a "substantive portion" of the services. CMS defined "substantive portion" as more than half of the total time spent on the service. CMS chose to phase in the implementation of this definition and to allow the history, physical examination, medical decision making (MDM) or more than half of the total time spent with a patient to determine the "substantive portion" of the visit. Starting in 2023, the definition was to be limited only to time spent with the patient, allowing the provider spending more than half of the total time to bill for these services.

In this rule, CMS finalized its proposal to delay the implementation of the new "substantive portion" definition to January 1, 2024. Despite stakeholders' reiteration of previous comments that the new definition focuses only on time spent, does not include MDM and may require changes to practice workflows to track time spent on visits, CMS maintained its approach. However, CMS will delay implementation to allow for the enactment of other policies related to E/M codes and to give providers more time to prepare for the policy. Clinicians may continue to use history, physical examination, MDM or more than half of the total time spent with the patient when defining "substantive portion" of split (or shared) services in 2023. CMS clarified that the split (or shared) services policy excludes critical care visits.

Telehealth and Other Remote Services

Key Takeaway: CMS maintained services added to the telehealth list during the PHE, will keep certain services until 151 days post-PHE and added several codes to Category 3.

During the COVID-19 PHE, the US Department of Health and Human Services (HHS) issued several waivers and flexibilities that made it easier to provide telehealth services to Medicare beneficiaries. These telehealth waivers provide flexibility regarding the locations where telehealth can be provided (*e.g.*, at home), which services can be provided, what type of technology can be used and the level of payment for telehealth services (*e.g.*, allowing the higher non-facility rate for office-based physicians).

In March 2022, Congress passed, and the president signed, an omnibus package that extended certain telehealth flexibilities for 151 days (approximately five months) after the PHE ends. Also in 2022, CMS finalized a temporary extension of telehealth coverage for certain services through CY 2023. This temporary extension will allow the agency to collect more data to inform the structure of telehealth coverage in a post-COVID-19 environment. As demand for telehealth has grown, CMS has sought to determine which services can be appropriately provided via telehealth from a clinical perspective. The agency has also acknowledged that expanded telehealth policies may help address access disparities.

In this final rule, CMS again noted that if the PHE remains in place well into CY 2023, the agency may revisit the length of the current extension (through the end of CY 2023). The agency also clarified that if the PHE is in effect for most of 2023 and the 151-day post-PHE period ends after December 31, 2023, the Category 3 services would remain on the Medicare Telehealth Services List through either December 31, 2023, or 151 days after the PHE, whichever date is later. The agency also maintained certain telehealth flexibilities (including telephone E/M services) that would have otherwise ended when the PHE ends, for 151 days post-PHE to align with the provisions of the omnibus package.

With the final rule, there are now two timeframes for codes to remain on the Medicare Telehealth Services List: 151 days post-PHE (Table 14 in CY 2023 PFS Final Rule) and the end of CY 2023. CMS also clarified that it could issue program guidance and/or other sub-regulatory guidance to provide more certainty to stakeholders on a post-PHE transition, as opposed to waiting until the CY 2024 rulemaking

process.

Key telehealth provisions in the final rule are outlined below.

Policy	Details
Extension of Temporary Additions to Medicare Telehealth List Through 151 Days Post-PHE	In the CY 2021 final rule, CMS provided coverage through the end of the PHE for more than 100 services added to the Medicare Telehealth List on an interim basis. Some services were added on a temporary interim basis, while others were given Category 3 status (Categories 1 and 2 represent the long-term criteria for additions to the telehealth list; Category 3 was created to allow additions not clearly fitting under Categories 1 and 2). Currently, Category 3 codes will remain on the list through the end of CY 2023. CMS finalized the extension of coverage for the services added on an interim basis (but not yet given Category 3 status) for 151 days post-PHE, to align with telehealth flexibilities included in the omnibus (Table 11 in CY 2023 PFS Final Rule).
Codes Granted Category 3 Status	CMS finalized more than 50 codes as Category 3 status (Table 12 in CY 2023 PFS Final Rule).
Five Permanent Additions to Medicare Telehealth List	While the proposed rule sought three new Healthcare Common Procedure Code System (HCPCS) codes on a Category 1 basis, the agency ultimately finalized the creation of five new HCPCS codes (Table 13 in CY 2023 PFS Final Rule).
Delay of In-Person Requirement for Mental Health Services	CMS finalized a delay to the in-person requirements for telehealth services furnished for purposes of diagnosis, evaluation or treatment of a mental health disorder until the 152nd day after the PHE ends.
Update of Telehealth Originating Site Facility Fee	The final rule applies an MEI increase of 3.8% for CY 2023. This is up from 3.7% in the proposed rule. CMS finalized an increase to the telehealth originating site facility fee from $27.59 in CY 2022 to $28.64 in CY 2023. This is an increase from $28.61 in the proposed rule.

Stakeholders should react favorably to CMS's efforts to align the timeframes for the end of certain Medicare telehealth flexibilities. However, the agency's ability to continue these flexibilities remains limited, and congressional action is necessary. To that end, the US House of Representatives recently passed legislation that would remove existing barriers, such as originating site and geographic restrictions, albeit on a temporary, two-year basis. The US Senate has not yet acted. Stakeholders are working to advocate for congressional action to extend these changes for more than 151 days, if not permanently, to provide increased certainty to patients and providers.

Key Takeaway: CMS did not finalize G codes for remote treatment management (RTM) services but gave additional clarity on supervision requirements for these services effective January 2023.

In recent years, CMS has established payment for several remote physiologic monitoring (RPM) codes. These codes generated significant stakeholder interest even prior to the pandemic. During the PHE, CMS implemented flexibilities to allow broader use of these services but provided limited guidance on how they should be reported. While utilization for some of the RPM codes again increased substantially compared to the previous year, CMS did not propose any policy changes specific to the RPM codes for 2023.

In last year's final rule, CMS introduced new RTM codes (98975–98981) that became effective January 1, 2022, and finalized payment rates for these new codes, similar to the RPM codes. CMS expressed concerns about a subset of the RTM codes and whether they could be billed (as intended) by a subset of practitioners (including physical and occupational therapists as well as speech language pathologists) outside the context of billing for incident-to services of a healthcare practitioner.

To address these concerns, this year CMS proposed four new HCPCS codes (GRTM1 and GRTM2). The first two codes would have allowed for the general supervision of auxiliary personnel by physicians and non-physician practitioners. The second set of codes (GRTM3 and GRTM4) would have allowed for the furnishing of services by qualified nonphysician healthcare professionals who cannot bill services furnished incident to their professional services. The valuation of these codes would not contemplate the incident-to activities.

Based on feedback from stakeholders, including concerns and confusion regarding these codes, CMS decided to not finalize these codes for CY 2023. While CMS did not finalize these codes, it did update and clarify its policy regarding supervision requirements for the RTM codes (98975, 98976, 98977, 98980 and 98981). As of January 1, 2023, any RTM services furnished may be done under general rather than direct supervision.

In the final rule, CMS also discussed requests for a new device RTM code but did not take any action because of concerns about the feasibility of a generic code for RTM and reaching consensus on valuation.

CMS also introduced the new RTM device code for cognitive behavioral therapy, 98978 (989X6 in the proposed rule) (Remote therapeutic monitoring (*e.g.*, therapy adherence, therapy response); device(s) supply with scheduled (*e.g.*, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavior therapy, each 30 days)). Because the devices in this space are still emerging and evolving, the AMA RVS Update Committee recommended that the code be contractor priced for CY 2023. CMS agreed and finalized this position effective January 1, 2023.

Potentially Misvalued Codes

Key Takeaway: CMS did not designate new misvalued codes.

The Affordable Care Act mandates a regular review of fee schedule rates for physician services paid by Medicare, including services that have experienced high growth rates. CMS established the potentially misvalued code process to meet this mandate. Codes identified for review under this process may

eventually have their values increased, decreased or maintained. The risk of reduced values is often a concern for stakeholders when one of their services is proposed for revaluation under this process.

Table 6 in the CY 2023 proposed rule provided codes for review that covered a range of services, such as home visits and ophthalmological services, including cataracts. After consideration of public comments, CMS did not adopt any of the nominated codes as potentially misvalued codes in the final rule.

Quality Payment Program

Under the QPP, eligible clinicians elect to either be subject to payment adjustments based upon performance under MIPS or participate in the Advanced Alternative Payment Model (APM) track. Eligible clinicians choosing the MIPS pathway have payments increased, maintained or decreased based on relative performance in four categories: Quality, Cost, Promoting Interoperability and Improvement Activities. Eligible clinicians choosing the APM pathway automatically receive a bonus payment once they meet the qualifications for that track. CMS will implement a new alternative to traditional MIPS, the MVPs, as a voluntary option starting in 2023.

MIPS Value Pathways

Key Takeaway: CMS will initiate MVPs in 2023 with 12 pathways.

The MVPs are a participation option to motivate clinicians to move away from reporting on self-selected activities and measures (traditional MIPS) and towards an aligned set of measure options designed to be meaningful to patient care, better connect measures across MIPS categories and be more relevant to a clinician's scope of practice. Over the years, participation in traditional MIPS has been criticized as expensive and time-consuming with low positive payment adjustments as a reward, and as having an uncertain impact on patient care. At the same time, some stakeholders have raised concerns about sunsetting MIPS because the MVPs are untested and it is unclear whether there will be MVP options for all participants. In the CY 2022 final rule, CMS finalized a proposal to launch the MVPs in 2023, set an implementation timeline and defined MVP criteria.

MVP Implementation Timeline

CMS will initiate the MVP program as a voluntary option, to provide time for MIPS-eligible clinicians to familiarize themselves with MVPs and begin preparing their practices for participation (*e.g.*, via system updates):

- For **2023, 2024 and 2025 performance years**, CMS will allow individual clinicians, single specialty groups, multispecialty groups, subgroups and APM entities to report MVPs.
- For the **2026 performance year** and future years, CMS will allow individual clinicians, single specialty groups, subgroups and APM entities to report MVPs. Multispecialty groups will be required to form subgroups in order to report MVPs. Subgroups have additional detailed reporting and scoring requirements.
- In last year's proposed rule, CMS proposed to move all clinicians to MVPs by 2027. However, CMS **has not finalized a definitive end date** for traditional MIPS and reiterated in this rule that such a determination has not been made.

MVP Criteria

Like MIPS, MVPs have different categories:

- **Quality Performance.** MVP participants will select four quality measures. One must be an outcome measure (or a high-priority measure if an outcome isn't available or applicable).

- **Improvement Activities Performance.** MVP participants will select two medium-weighted improvement activities, one high-weighted improvement activity or participation in a patient-centered medical home.
- **Cost Performance.** MVP participants will be scored on the cost measures included in the MVP that they select and report.
- **Foundational Layer:**
  - Population Health Measures. At the time of MVP registration, participants will select one population health measure, and the results will be added to the quality score.
  - Promoting Interoperability Performance. MVP participants will report on the same promoting interoperability measures required under traditional MIPS unless they qualify for reweighting.

New MVPs

CMS finalized five new MVPs that will be available beginning with the 2023 performance year:

- Advancing Cancer Care
- Optimal Care for Kidney Health
- Optimal Care for Patients with Episodic Neurological Conditions
- Supportive Care for Neurodegenerative Conditions
- Promoting Wellness.

CMS established seven MVPs in last year's final rule and in this year's rule offered refinements to each:

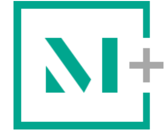
- Advancing Rheumatology Patient Care
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
- Advancing Care for Heart Disease
- Optimizing Chronic Disease Management
- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
- Improving Care for Lower Extremity Joint Repair
- Patient Safety and Support of Positive Experiences with Anesthesia.

MVP participants will not be able to submit or make changes to the MVP they select after the close of the registration period and will not be allowed to report on an MVP for which they did not register. CMS stated that going forward it will broaden the opportunity for the public to provide feedback on MVP candidates and updates to existing MVPs.

Scoring

MVP scoring policies will generally align with those used in traditional MIPS across all performance categories, including policies regarding performance category weights.

Some stakeholders may raise concerns about whether MVPs are a sufficient departure from the current program and whether MVP options will be available for all participants and specialties. It will be interesting to observe which physicians and entities choose to move forward with the MVPs in 2023 and how fast the transition away from traditional MIPS occurs.



Merit-Based Incentive Payment System

Key Takeaway: CMS maintained the current program threshold to avoid a MIPS penalty.

To avoid a negative adjustment in the 2023 performance year/2025 payment year, providers' MIPS total score must reach a performance threshold. CMS will maintain the MIPS performance threshold for the 2023 performance year at 75 points, the same as the last performance year. The 2023 MIPS performance threshold was set using the mean score from the 2019 performance year. Historically, CMS has increased the MIPS performance threshold, making participation more challenging, and the agency noted that it could have finalized a threshold as high as 89 points. Individuals and groups receiving fewer than 75 points will incur a payment penalty on a linear sliding scale of up to 9%, with those scoring under 18.75 points incurring an automatic 9% negative adjustment. Unless Congress acts, there is no exceptional performance bonus for 2023.

Changes to MIPS Performance Categories and Weights

CMS updated the measures in the various performance categories for the 2023 performance year:

- **Quality** – 198 total measures, including nine additions (one new administrative claims measure, one composite measure, five high-priority measures and two new patient-reported outcome measures)
- **Cost** – addition of the Medicare Spending Per Beneficiary Clinician measure as a care episode group
- **Improvement Activities** – addition of four new activities, modifications to five existing activities and removal of six activities
- **Promoting Interoperability** – expansion of the query of prescription drug monitoring programs to include not only Schedule II opioids, but also Schedule III and IV drugs, and addition of a new Health Information Exchange Objective option, Participation in the Trusted Exchange Framework and Common Agreement, plus additional changes outlined in more detail in the QPP fact sheet.

CMS expanded the definition of "high-priority measures" to include health-equity-related quality measures. The agency also stated that it will begin to measure improvement for the cost performance category for the first time, with a maximum cost improvement score of 1 percentage point. For the 2022 performance period, however, MIPS-eligible clinicians will receive a cost improvement score of 0, because the agency did not calculate cost measure scores for the 2021 performance period.

The MIPS performance category weights are summarized below. Since these are specified in statute, they were not changed from the previous year.

Performance Category	PY 2022 Weight	PY 2023 Proposed Weight
Quality	30%	30%
Cost	30%	30%
Promoting Interoperability	25%	25%
Improvement Activities	15%	15%

For the 2023 performance period, the data completeness threshold remains at 70% as finalized in the CY 2022 final rule. In this rule, CMS finalized an increase in the threshold to 75% for the 2024 and 2025 performance periods.

In recent years, participation in MIPS has decreased because of COVID-19-related exemptions. As the

end of the PHE potentially approaches, it remains to be seen whether this trend will have any long-term impact on the program and whether more clinicians will choose to participate via the MVPs.

Advanced APM Track

Key Takeaway: The Advanced APM incentive payment expires at the end of 2022.

MACRA included a 5% incentive payment for clinicians participating in advanced APMs through the 2022 performance year/2024 payment year. Absent congressional action, those payments are set to expire this year.

In performance year 2024/payment year 2026, MACRA provides for two different CFs depending on advanced APM participation. Eligible clinicians who are qualifying participants in advanced APMs will receive a differentially higher 0.75% update to the CF compared to the 0.25% update to the general CF each year.

In the final rule, CMS reiterated its concern that the structure of the MACRA payment system could result in higher payments through MIPS in absence of the advanced APM bonuses, even accounting for the CF differential. CMS stated that this could shift clinicians into MIPS and out of advanced APMs.

Stakeholders will be looking to Congress to extend the advanced APM bonus in an end-of-year legislative package.

Medicare Shared Savings Program

Key Takeaway: CMS finalized new advanced investment payments (AIPs) to certain ACOs.

In October 2021, the CMS Innovation Center announced its refreshed strategy, including a new objective that all Medicare beneficiaries be in a care relationship with accountability for quality and total cost of care by 2030, and a second objective advancing health equity. In this rule, CMS finalized policy changes aimed at bolstering these goals. CMS created an option for AIPs to certain ACOs, intended to increase participation in accountable care models in underserved communities. This new option builds on the success of the ACO Investment Model (an Innovation Center model that tested the effects of advanced payments to certain ACOs participating in the MSSP) and will allow low-revenue ACOs that are inexperienced with performance-based risk and are new to the MSSP to receive advanced payment of their shared savings for the first two years of their five-year agreement period.

AIPs will include a one-time fixed payment of $250,000 and quarterly payments based on risk factors for the beneficiary population, capped at 10,000 assigned beneficiaries. The final rule lays out criteria for participation, calculating the payment amount, use of the pre-paid funds, repayment and other details of the new option. Most of the proposals related to this program were finalized as proposed, with some minor modifications.

Key Takeaway: CMS finalized changes to the MSSP intended to drive participation.

CMS finalized numerous changes to the MSSP intended to increase participation and address stakeholder concerns about benchmarking accuracy. These changes include the following:

- Allowing inexperienced ACOs to participate in the MSSP in upside-only shared savings for seven years before transitioning to two-sided risk (one five-year agreement under BASIC level A and a second agreement with the BASIC level glidepath, allowing two years under one-sided risk)
- Removing the limitation on the number of agreement periods in which an ACO can participate in BASIC Level E, and making participation in ENHANCED optional
- Implementing a combination of benchmarking policies that incorporate a prospective, external factor into the methodology for updating historical benchmarks, incorporate a prior savings

adjustment and reduce the impact of the negative regional adjustment

- Modifying the risk adjustment methodology to account for medically complex, high-cost beneficiaries, while continuing to address the agency's concerns about coding practices
- Using a sliding scale approach to ACO eligibility for shared savings based on quality performance (as opposed to the current cliff-like approach where ACOs that do not meet established thresholds do not share in any savings)
- Extending the incentive for reporting electronic clinical quality measures (eCQMs)/MIPS CQMs through performance year 2024 to align with sunsetting of the CMS Web Interface reporting option
- Implementing a health equity adjustment of up to 10 bonus points for an ACO's MIPS quality performance category score when reporting all-payer eCQMs/MIPS CQMs based on quality performance and providing care to a higher proportion of underserved or duals
- Reducing administrative burden for ACOs by removing requirements around CMS review of marketing materials and modifying requirements for beneficiary notice, removing the requirement that ACOs apply for the skilled nursing facility three-day rule waiver and replacing it with an attestation, and updating data-sharing regulations
- Revising the definition of primary care services used for beneficiary alignment to incorporate new prolonged service codes and new chronic pain management (CPM) codes.

Changes that afford some types of participants additional time in upside-only arrangements may increase participation in the MSSP, consistent with the administration's goals. The changes to benchmarking and risk adjustment will need to be modeled to determine whether they meet stakeholder needs. CMS emphasized that this is the beginning of a dialogue with ACO stakeholders about modifications to the program.

Requests for Information

Health Equity Initiative

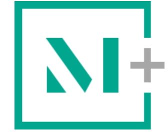
Key Takeaway: CMS outlined support for, but did not finalize, two new social drivers of health screening measures in the APM performance pathway measure set.

President Biden signed the Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government on January 20, 2021, and thereby directed agency leadership to review, manage and establish policy using an equity lens. In response, HHS has advanced health equity through many policies and actions, and has sought input on other policy changes through various requests for information.

In the CY 2023 PFS proposed rule, CMS sought feedback on the potential inclusion of two new measures in the APM performance pathway measure set:

- Screening for social drivers of health
- Screen positive rate for social drivers of health.

In the final rule, CMS noted its commitment to health equity but did not finalize these measures. The agency noted that any changes to the measures included in the APM performance pathway measure set, including the addition of new measures, will be proposed through future rulemaking.



Other Proposals

Behavioral Health

Key Takeaway: CMS finalized efforts to expand access and address shortages in behavioral services and health providers.

Efforts to address behavioral health have gained momentum, especially in the wake of the COVID-19 pandemic and significant gun violence events. While Congress considers several mental health bills, regulators are working to expand access to behavioral health services for Medicare beneficiaries. CMS finalized two policies to achieve this objective:

- To allow licensed professional counselors and licensed marriage and family therapists to bill Medicare under general supervision
- To create a new code (G0323) for general behavioral health integration services to be performed by clinical psychologists and clinical social workers when they are the focal point of integration.

These changes are intended to improve access by allowing the provision of behavioral health services without a doctor or nurse practitioner physically onsite, and by paying for psychologists and social workers to help manage behavioral health needs as part of the primary care team. CMS finalized its proposal to crosswalk G0323 to 99484 with a work value of 0.61 because the agency believes services under G0323 mirror those under 99484. To support the use of the new code, CMS finalized its proposal to allow the psychiatric diagnostic evaluation CPT code 90791 to serve as the initiating behavioral health visit, which is required for all behavioral health integration services. Prior to this change, no CPT codes have been eligible to be used for the initiating visit requirement.

Chronic Pain Management Services

Key Takeaway: CMS finalized its proposal to create two codes for CPM services.

CMS established the following two codes for CPM services effective January 1, 2023.

Code	Description
G3002	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/or 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, for example, physical therapy and occupational therapy, complementary and integrative approaches, 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. (When using HCPCS code G3002, 30 minutes must be met or exceeded)
G3003	Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month

CMS does not believe that existing E/M codes appropriately represent the resources and services required to perform CPM services and asserted its authority to establish the new codes. CMS finalized its proposal to crosswalk G3002 to the work RVU (1.45) and PE of principal care management code 99424, given the similar services performed under each code. CMS also finalized its proposal to crosswalk G3003 to principal care management code 99425 with half the work RVU (proposed at 0.50) and half the PE values, based on the comparable services. The final code descriptor for G3002 adds "complementary and integrative approaches" to the list of example services described by the code.

CMS finalized many of the parameters of the new codes as proposed with a few exceptions. CMS will allow G3003 to be billed an unlimited number of times as medically necessary and will allow telehealth services for furnishing G3002 and G3003 services. CMS clarified in the final rule that a beneficiary does not need to have "an established history or diagnosis of chronic pain or be diagnosed with a condition that causes or involves chronic pain" for the first CPM visit.

Refunds for Discarded Amounts of Single-Dose or Single-Use Package Drugs

Key Takeaway: CMS finalized its proposals regarding manufacturer refunds for discarded amounts of single-dose container or single-use package drugs.

Section 90004 of the Infrastructure Investment and Jobs Act, signed into law on November 15, 2021, requires manufacturers to provide a refund to CMS for certain discarded amounts from single-dose container or single-use package drugs. CMS finalized its proposal that hospital outpatient departments and ambulatory surgery centers be required to report the JW billing modifier to determine the total number of billing units of the HCPCS code of a refundable drug, with a few exceptions. CMS also finalized its proposal to require the establishment and use of a JZ billing modifier for providers to indicate that no amount of the drug was discarded.

These policies are applicable to Medicare Part B drugs described as "single-dose" or "single-use" within the US Food and Drug Administration approved label. CMS finalized its proposal to exclude radiopharmaceuticals and imaging agents, as well as drugs requiring filtration, from these requirements. CMS also finalized its proposal to exclude drugs for which payment under Medicare Part B has been made for fewer than 18 months (using the first day of the quarter following the date of first sale of the drug reported to CMS).

CMS finalized its proposal to send manufacturers annual reports containing data and calculated refund amounts, and to require manufacturers to pay refunds on an annual basis. CMS stated its intention to address the timing of the reporting in future rulemaking and will release a preliminary report on estimated discarded amounts by December 31, 2023.

The refund amount will be equal to the amount by which the product of the total number of units of drug discarded and the Medicare payment limit of the drug exceeds 10% of the drug's total allowed charges (*i.e.*, the amount Medicare paid) during the quarter. CMS also finalized its proposal to implement a dispute resolution process and civil monetary penalty for failure to comply.

Clinical Laboratory Fee Schedule

Key Takeaway: CMS finalized conforming changes to the Protecting Access to Medicare Act of 2014 (PAMA) data reporting and payment requirements.

In December 2021, Congress passed the Protecting Medicare and American Farmers from Sequester Cuts Act, which further delayed the data reporting timeline for data collected in Q1 and Q2 2019. That law established the data collection period as January 1, 2023, through March 31, 2023, for rates that would become effective January 1, 2024. The law also stated that clinical laboratory fee schedule rates could not be reduced between 2021 and 2022, and that payment rates in CYs 2023–2025 may not drop by more than 15% each year when compared to the preceding year.

CMS proposed to make conforming changes to reflect the most recent changes to the PAMA data reporting requirements and payment requirements. In this final rule, CMS finalized the necessary conforming changes to reflect the current requirements. The agency did not make any changes to the data collection period, the data reported in said collection period, or the limit on the payment rate changes in the upcoming calendar years as those changes are statutory in nature. PAMA reform legislation is currently pending in Congress, and these changes may be considered during the lame duck session in December. Congress may provide some additional delay for payment cuts expected in 2023.

Key Takeaway: CMS updated, codified and clarified its specimen collection and travel allowance policies.

Section 1833(h)(3)(a) of the Social Security Act allows for the payment of a nominal fee for specimen collection for laboratory testing performed on a Medicare patient and paid under Medicare Part B. CMS proposed to codify its existing specimen collection policies, while excluding language for policies that no longer apply. Based on feedback from stakeholders, CMS updated the specimen collection fee from $3 to $8.57, based on CPI-U updates from June 1984 through June 2022. CMS also finalized a policy to update the specimen amount each year (through subregulatory guidance) based on the CPI-U for the 12 months preceding the update (June to June). Consistent with its existing policy, CMS codified a nominal increase in the specimen collection fee ($2) that only applies where the lab collected the specimen on behalf of a home health agency or from a patient in a skilled nursing facility and the specimen is used to perform a clinical diagnostic laboratory test. The fee will apply to only two types of specimen collection for which HCPCS codes exist: blood collected through venipuncture and urine sample by catheterization. CMS did not propose to extend the specimen collection fee for COVID-19 clinical diagnostic laboratory tests beyond the end of the PHE.

Section 1833(h)(3)(b) of the Social Security Act allows for the payment of a travel allowance fee to cover the transportation expenses of trained personnel traveling to a location to collect a specimen from a Medicare beneficiary. In response to questions received during the pandemic regarding travel allowance policies, CMS codified its existing policies with the following revisions. CMS clarified its definition of eligible miles: these miles begin at the laboratory or the location from which the technician is starting her travel for the specimen collection, and they end at the ending point for the technician's specimen collection or at the laboratory where the specimen is returned. Updates to the mileage rate and the wage rate for the phlebotomist will be published through sub-regulatory guidance.

Appropriate Use Criteria Program

Key Takeaway: CMS delayed the penalty phase of the appropriate use criteria (AUC) program for an indeterminate period of time.

Section 218(b) of PAMA established the AUC program, under which a practitioner who orders an advanced diagnostic imaging service for a Medicare beneficiary in an applicable setting is required to consult an AUC using a qualified clinical decision support mechanism. The practitioner furnishing the imaging service must report the AUC consultation information on the Medicare claim.

In the CY 2018 rulemaking cycle, CMS established January 1, 2020, as the AUC program's effective date, with the first year serving as the operations and education testing period. In July 2020, in response to the COVID-19 PHE, CMS extended the testing period an additional year. In the CY 2022 PFS final rule, CMS finalized its policy to delay the payment penalty phase of the AUC program until January 1, 2023, at the earliest.

While neither the CY 2023 PFS proposed rule nor the final rule include any substantive changes to the AUC program, CMS did further delay the penalty phase of the program in conjunction with the release of the proposed rule. CMS stated on the AUC program website that the educational and testing program will continue until further notice, and that the penalty phase will not begin on January 1, 2023. CMS also

announced that any clinical decision support mechanisms and provider-led entities that were qualified as of July 2022 would remain qualified. CMS will not accept applications for new clinical decision support mechanisms or provider-led entities for the 2023 cycle.

Expansion of Coverage for Colorectal Cancer Screening

Key Takeaway: CMS finalized two updates to expand Medicare coverage policies for colorectal cancer (CRC) screening.

CMS finalized its proposal to expand Medicare coverage for certain CRC screening tests by reducing the minimum age limitation from 50 years to 45 years. This is in line with the revised recommendation (with a Grade B) from the US Preventive Services Task Force issued in May 2021. CMS also finalized its proposal to expand coverage for barium enema tests and blood-based biomarker tests to a minimum age of 45, even though that change was not included in the task force recommendation. CMS otherwise retained the existing frequency limitations. Ultimately, the impact of this change may be limited, given that the majority of the Medicare population is 65 years or older.

CMS also finalized its proposal to expand the regulatory definition of CRC screening tests to include a follow-on screening colonoscopy after a positive result from a Medicare covered non-invasive stool-based CRC screening test. Currently, a colonoscopy after a positive result from a CRC screening stool-based test is considered “diagnostic” or a treatment/management of the medical problem. With this change, the beneficiary cost sharing will not be applicable for the stool-based test or the follow-up colonoscopy.

Update to Current Payment Policies for Dental Services

Key Takeaway: CMS finalized multiple proposals to expand dental coverage.

Medicare Parts A and B currently pay for dental services in a limited number of circumstances, specifically when a service is an integral part of specific treatment of a beneficiary’s primary medical condition. CMS believes that there are additional circumstances where Medicare payment should be made. In the final rule, CMS finalized its proposal for payment for dental examinations and necessary treatment performed as part of a comprehensive workup prior to organ transplantations (including hematopoietic stem cell and bone marrow transplantations), cardiac valve replacement and valvuloplasty procedures that are inextricably linked to, and substantially related and integral to, the clinical success of an otherwise covered medical service.

CMS originally proposed Medicare payment under Parts A and B for dental services prior to treatment for head and neck cancers as an additional example of these integral treatments. However, CMS decided to finalize this proposal for CY 2024 instead of CY 2023. CMS also decided not to finalize its proposal for payment for dental services prior to the initiation of immunosuppressant therapy, joint replacement surgeries or other surgical procedures. CMS believes that additional time is necessary to consider the inextricable link between dental services and these covered medical services.

CMS finalized the CY 2023 establishment of an annual process for the review of public nominations of additional dental services that could be covered and paid, setting up the potential for greater expansion in future years.

Conclusion

The CY 2023 PFS final rule highlights continued problems with physician payment, and great uncertainty remains about final Medicare reimbursement rates. Stakeholders are turning to Congress to seek relief, and some congressional action on these issues is likely by the end of the year. Lawmakers’ appetite to continuously patch physician payments is also unclear. While stakeholders are urging Congress to address cuts in 2023, there are also calls for Congress to find a more permanent solution to avoid the annual patches to the PFS.

Other policies in this rule set up significant changes for 2023 and beyond, including potential changes to participation in ACOs and the MVPs. These policies will test whether physicians intend to continue current quality efforts or begin a greater movement toward the Administration's goal of value-based care. Consequently, it will be important to see how this impacts performance in next year's rulemaking.

For more information, contact Haile Dagne, Deborah Godes, Rachel Hollander, Marie Knoll, Mara McDermott or Kristen O'Brien.

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