AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Summary of the CY 2023 Medicare Physician Fee Schedule final rule

On November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) released the CY 2023 Medicare Physician Fee Schedule (MPFS) final rule. This regulation also impacts the Quality Payment Program (QPP). CMS released accompanying fact sheets on the MPFS, Medicare Shared Savings Program, and QPP changes. The provisions in the final rule will take effect on January 1, 2023, except where otherwise specified in the rule.

2023 Medicare Conversion Factor (CF) and Estimated Impact on Family Medicine

The conversion factor for 2023 is $33.06. This is about 4.5 percent lower than the 2022 conversion factor. This reduction can be attributed to the expiration of a 3 percent increase in the 2022 conversion factor, which Congress applied via legislation. The remaining 1.5 percent reduction is due to budget neutrality adjustments that CMS is required to make to offset spending increases from regulatory changes that increase relative value units for some services. The AAFP is strongly advocating to avert the payment cuts that will result from this reduction, as well as implement an annual payment update for physicians.

Evaluation and Management (E/M) Visits

CMS finalized its proposal to adopt most of the changes in coding and documentation for Other E/M visits (which include hospital inpatient, hospital observation, emergency department, nursing facility, home or residence services, and cognitive impairment assessment) recommended by the American Medical Association's CPT and RUC panels effective January 1, 2023. These changes allow time or medical decision-making to be used to select the E/M visit level.

CMS finalized its proposal to create Medicare-specific coding for payment of Other E/M prolonged services, like what CMS adopted in CY 2021 for payment of Office/Outpatient prolonged services. Beginning in 2023, the following codes may be used for prolonged services for Other E/M services:

- G0316 – prolonged Hospital Inpatient and Observation Care evaluation and management service(s) beyond the total time for the primary service; each additional 15 minutes
- G0317 – prolonged Nursing Facility evaluation and management service(s) beyond the total time for the primary service; each additional 15 minutes
- G0318 – prolonged Home or Residence evaluation and management service(s) beyond the total time for the primary service; each additional 15 minutes

CMS did not finalize its proposal that prolonged services would not be reportable with Cognitive Assessment and Care Planning services (CPT code 99483). Instead, CMS is revising G2212 to allow it to be reported with CPT code 99483 for prolonged services.

Rebasing and Revising the Medicare Economic Index (MEI)

The MEI is an index that measures changes in the market price of the inputs used to furnish physician services. The current MEI is primarily based on 2006 data. CMS finalized its proposal to rebase and revise the MEI based on a methodology that uses the 2017 U.S. Census Bureau's Services Annual Survey data for input costs that represent all types of physician practice ownership; that is, not limited to only self-employed physicians. The final rebasing and revising includes some technical revisions to

the proposed method based on public comments. Because the new MEI cost weights would likely result in significant changes to payments among PFS services, the rebased and revised MEI weights were not used in CY 2023 PFS rate setting to ensure payment stability. The final CY 2023 MEI update is 3.8 percent.

Determination of Practice Expense Relative Value Units (PE RVUs)

CMS is finalizing a series of standard technical proposals involving practice expense, including the implementation of the second year of the clinical labor pricing update consistent with AAFP advocacy.

Payment for Medicare Telehealth (TH) Services Under Section 1834(m) of the Act

Services temporarily included on the [Medicare Telehealth Services List]() on a Category 3 basis will remain included through at least the end of CY 2023. If the PHE is in effect through December 31, 2023, Category 3 services would remain on the list for 151 days after the PHE.

CMS will also continue paying for services included on the TH List as of March 15, 2022, that are furnished in an audio-only telecommunications system for 151 days after the end of the PHE.

In response to AAFP advocacy and concerns from other stakeholders, CMS agreed to continue paying for Medicare telehealth services as though they were provided in-person, instead of reducing payments for telehealth to the facility rates, through the end of 2023. Practitioners should continue to bill telehealth services with modifier 95 along with the POS corresponding to where the service would have been furnished in-person. For TH services provided on or after the 152nd day after the end of the PHE, CMS will require services to be reported using either place of service (POS) 02 (Telehealth Provided Other than in Patient’s Home) or POS 10 (Telehealth Provided in a Patient’s Home).

With the AAFP’s support, CMS delayed the in-person requirements for tele-mental health visits, including those furnished by rural health clinics (RHCs) and federally qualified health centers (FQHCs). CMS clarified that the in-person non-telehealth visit within six months prior to the first mental health service is furnished via TH does not apply to beneficiaries who began receiving mental health TH services during the PHE or during the 151-day period after the end of the PHE. Beneficiaries that began receiving mental health TH service during the PHE will be considered established and instead required to have at least one in-person visit every 12 months.

All providers, including FQHCs, RHCs, and OTPs must append Medicare modifier “FQ” (*Medicare telehealth service was furnished using audio-only communication technology*) for allowable audio-only services provided in those settings. CMS is also finalizing its proposal to require all providers including RHCs, FQHCs, and OTPs to use modifier -93 for all eligible mental health services provided via audio-only telecommunications technology. Providers will have the option to use the FQ or -93 modifiers or both, where appropriate and true, since they are identical in meaning. Supervising practitioners would continue to use the FR modifier on applicable claims when required to be present through an interactive real-time audio and video telecommunications link, as reflected in each service’s requirements.

Following the 151-day post-PHE extension period, CMS will assign the telephone E/M services (CPT 99441-99443) codes a “bundled” status to telephone E/M services (CPT 99441-99443). The AAFP continues to advocate for permanent coverage and payment for audio-only telehealth services after the end of the PHE.

CMS added several emotional/behavior assessment, psychological, and neuropsychological testing and evaluation services to the TH List on a Category 3 (temporary) basis. CMS also added the newly finalized prolonged services (HCPCS codes G0316, G0317, and G0318) as well as the chronic pain management codes (HCPCS codes G3002 and G3003) to the TH List on a Category 1 (permanent) basis.

Valuation of Specific Codes

CMS addresses the valuation of specific codes within the Medicare physician fee schedule. Among those of most interest to family physicians:

Immunization Administration (CPT codes 90460, 90461, 90471, 90472, 90473, and 90474): Consistent with the AAFP's recommendations, CMS finalized the RUC recommended work RVUs for all six immunization administration codes and did not finalize the clinical labor time proposal and will restore the 1 minute of clinical labor time for the CA008 activity for CPT codes 90460 and 90471-90474. CMS finalized all other proposals to refine the direct PE inputs for these codes.

Code Descriptor Changes for Annual Alcohol Misuse and Annual Depression Screenings (HCPCS codes G0442 and G0444): As requested by the AAFP, CMS modified the descriptor for HCPCS code G0442 to read "Annual alcohol misuse screening, 5 to 15 minutes" and for HCPCS code G0444 to read "Annual depression screening, 5 to 15 minutes."

Chronic Pain Management and Treatment (CPM) Bundles (HCPCS G3002 and G3003): CMS finalized separate coding and payment for chronic pain management (CPM) services beginning January 1, 2023 and permanently added these codes to the Medicare telehealth services list. CMS will allow NPPs to provide this service and requires the initial visit to be face-to-face. Specifically, CMS created two HCPCS codes to describe monthly CPM services as follows:

- HCPCS code 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 e.g. 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 G3002, 30 minutes must be met or exceeded.)

- HCPCS code G3003: Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month (List separately in addition to code for G3002). (When using G3003, 15 minutes must be met or exceeded.)

Proposed Revisions to the "Incident to" Physicians' Services Regulation for Behavioral Health Services: CMS will allow behavioral health services to be furnished under the general supervision of a physician or nonphysician provider (NPP) (instead of direct supervision) when these services or supplies are provided by auxiliary personnel incident to the services of a physician or NPP.

New Coding and Payment for General Behavioral Health Integration (BHI) billed by Clinical Psychologists (CPs) and Clinical Social Workers (CSWs): CMS created a new code (HCPCS G0323) describing general behavioral health integration performed by clinical psychologists or clinical social workers on a monthly basis and will allow general supervision for the new code.

Geographic Practice Cost Indices (GPCI)

CMS finalized its proposal to update the GPCIs using more recent wage, office rent, and malpractice premium data. The adjustment will be phased in over calendar years (CYs) 2023 and 2024. For the CY 2023 GPCIs, CMS will continue to use the current 2006-based MEI cost share weights rather than the rebased and revised MEI cost share weights discussed elsewhere in the final rule.

Medicare Part B Payment for Preventive Vaccine Administration Services

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

Medicare Parts A and B Payment for Dental Services

CMS finalized proposals to codify payment under Medicare Parts A and B for dental services that are closely linked to or required for an otherwise covered medical service.

Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers

CMS reduced minimum age for coverage of certain colorectal cancer screening tests from 50 to 45 years of age. CMS also finalized expanded coverage of colorectal cancer screening to include a follow-on screening colonoscopy after a non-invasive stool-based test returns a positive result, thereby removing cost sharing for most beneficiaries.

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

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

CMS also finalized regulations to allow the OTP intake add-on code to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with buprenorphine (to the extent that the use of audio-video technology is authorized by the Drug Enforcement Administration and Substance Abuse and Mental Health Services Administration). . In cases where two-way audio-video communications technology is not available to the beneficiary, services to initiate treatment with buprenorphine can be furnished using audio-only telephone calls if all other applicable requirements are met.

CMS modified regulations to allow periodic assessments of buprenorphine treatment to be furnished via audio-only technology when video is not available through the end of CY 2023.

CMS clarified that OTPs are able to bill Medicare for medically reasonable and necessary services furnished via mobile units. For the geographic adjustment, OUD treatment services furnished via an

OTP mobile unit will be treated as if the services were furnished at the physical location of the registered OTP, not the location in which the unit operates.

Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan

Prescription drug event (PDE) data is provided to CMS by drug plan sponsors every time a beneficiary fills a prescription under Medicare Part D; this data is used to evaluate prescriber compliance with Electronic Prescribing for Controlled Substances (EPCS) requirements. Enforcement of EPCS compliance begins in CY 2023; CMS planned to use PDE data from the preceding year to evaluate EPCS compliance for the current year. CMS will instead use current year data as soon as it is available to evaluate EPCS compliance.

Starting in CY 2025, CMS will begin increasing the severity of penalties for noncompliant prescribers, from issuance of non-compliance letters to other penalties, and is seeking comments on potential non-compliance penalties.

Clinical Laboratory Fee Schedule: Revised Data Reporting Period and Phase-in of Payment Reductions

In accordance with current law, CMS is making certain conforming changes in the regulations related to the data reporting and payment requirements. As a result, the CY 2023 CLFS payment rates will generally be based on applicable information collected between January 1, 2016, and June 30, 2016. The CLFS payment rates for CY 2024 through CY 2026 will be based on applicable information collected during the period of January 1, 2019 through June 30, 2019 and reported to CMS during the data reporting period of January 1, 2023 through March 31, 2023. The AAFP will continue to advocate to avert these payment reductions.

Medicare Shared Savings Program (MSSP)

CMS finalized a number of changes to the Shared Savings Program which are directionally consistent with the AAFP's advocacy to improve value-based care participation opportunities for FPs, particularly those caring for rural and other underserved populations.

Advanced payments: Beginning in 2024, CMS will make advanced shared savings payments available to low revenue accountable care organizations (ACOs) that are inexperienced with performance-based risk Medicare ACO initiatives and that are new to MSSP. Advance investment payments (AIPs) would increase when more dual-eligible beneficiaries or beneficiaries who live in areas with high deprivation are assigned to the ACO. Payments would be used to improve health care provider infrastructure, increase staffing, or provide accountable care for underserved beneficiaries. CMS proposes AIPs be comprised of two types of payments: a one-time payment of $250,000 and eight quarterly payments (for the first two years of the 5-year agreement period) based on the number of assigned beneficiaries, capped at 10,000 beneficiaries. CMS would recoup prepaid shared savings (AIP) from any shared savings earned by an ACO in its current agreement period, and if necessary, future agreement periods.

Participation Glide Path: In an effort to reduce barriers to participation, CMS proposes to revise its participation options. For agreement periods beginning in 2024 and subsequent years, CMS will allow ACOs inexperienced with performance-based risk to enter and remain in BASIC track Level A for all 5 years of the agreement period. These ACOs may be eligible for a second agreement period within the BASIC track's glide path, with two additional years under a one-sided model (for a total of 7 years

before transitioning to two-sided risk). ACOs participating in Level A or B in 2023 or 2024 have the option to elect to continue in their current level of the BASIC track for the remainder of their agreement. For agreement periods beginning in 2024, there will be no limit on the number of agreement periods an ACO can participate in Level E of the BASIC track, making participation in the ENHANCED track completely optional.

Quality: CMS will reinstate a modified sliding scale approach for determining shared savings. Beginning in 2023, ACOs that fail to meet the existing criteria under the quality performance standard to qualify for maximum sharing rate may be eligible to share in savings at a lower rate if the ACO achieves a quality score in the 10th percentile or higher for at least one of the four outcome measures in the APM Performance Pathway (APP) measure set. The ACO's sharing rate would be scaled to reflect the ACO's quality score.

CMS is finalizing a similar policy for determining an ACO's shared loss rate in the ENHANCED track. CMS will determine an ACOs shared loss rate using a sliding scale if an ACO has losses that exceed the minimum loss rate and either meets the existing quality performance standard or achieves a quality performance score at least equivalent to the 10th percentile for at least one of the four outcome measures in the APP set.

To allow ACOs additional time to gauge their performance under the APP measure set, CMS finalized an extension to the incentive for reporting via eCQMs/Merit-based Incentive Payment System Clinical Quality Measures (MIPS CQMs) through the 2024 performance year. CMS finalized the addition of a health equity adjustment to the MIPS quality performance scores for ACOs that report the three eCQMs/MIPS CQMs, meet the data completeness criteria, and administer the CAHPS for MIPS survey. The adjustment will be worth up to 10 bonus points. CMS modified its proposal to identify ACOs serving larger populations of underserved beneficiaries and will use the higher of the proportion of an ACO's assigned beneficiaries that are (1) dually eligible or enrolled in the Part D Low Income Subsidy (LIS), or (2) the proportion of beneficiaries residing in areas of high socioeconomic disadvantage (based on the area deprivation index).

Financing and benchmarking: CMS finalized several changes to the financial methodology, including:

- Incorporation of a prospective administrative growth factor into a three-way blend with national and regional growth rates to update an ACO's historical benchmark,
- Reinstituting an adjustment for prior savings when establishing benchmarks for renewing and re-entering ACOs,
- Reducing the cap on negative regional adjustments.

CMS finalized modifications to the existing three percent cap on risk score growth.

CMS will allow certain ACOs participating in the BASIC track that do not meet the minimum savings rate to qualify for shared savings. Under the new policy, an ACO would still need to meet the quality standard or finalized alternative quality standard. Additionally, the ACO's Parts A and B FFS expenditures must be below the updated benchmark, the ACO must be considered low revenue, and have at least 5,000 assigned beneficiaries at the time of financial reconciliation.

CMS finalized several modifications aimed at reducing administrative burden for SSP participants.

Updates to the Quality Payment Program

MIPs Value Pathways (MVPs)

CMS will implement MVPs, a streamlined MIPS reporting option, beginning in CY 2023. CMS finalized modifications to the MVP development process to provide additional opportunities for public feedback.

For the purposes of MVPs, CMS finalized the definition of a single specialty group to mean a group that consists of one specialty type as determined by CMS using Medicare Part B claims. A multispecialty group would be a group consisting of two or more specialties as determined by CMS using Part B claims.

CMS finalized five new MVPs and modifications to the seven previously established MVPs. Among the new MVPs is the Promoting Wellness MVP targeting preventive care.

To inform future policies, CMS finalized that subgroups must provide a description of each subgroup that it registers. Additionally, CMS finalized that individual eligible clinicians (represented by a TIN-NPI combination) will be limited to one subgroup within the group's TIN.

MIPS Quality

CMS expanded the definition of a high priority measure to include health equity-related measures. CMS finalized changes to its quality measure inventory. ECs will have 198 quality measures available to report for the 2023 performance year. CMS finalized revisions to the CAHPS for MIPS survey to add adjustors for Spanish language spoken at home, Asian language spoken at home, and other language spoken at home. Based on CMS' analysis, CMS will increase the data completeness criteria threshold to 75 percent for the 2024 and 2025 MIPS performance years. The data completeness criteria threshold is 70 percent for the 2023 performance year.

MIPS Improvement Activities

CMS updated its improvement activities inventory to include four new improvement activities, modify five existing activities, and remove six previously adopted activities.

MIPS Promoting Interoperability

Beginning with the 2023 performance period, CMS finalized a new requirement that MIPS eligible clinicians (ECs) must report the Query of Prescription Drug Monitoring Program (PDMP) measure for the promoting interoperability category. The measure will be expanded to include Schedule III and IV drugs in addition to Schedule II opioids.

CMS finalized a new measure that allows ECs to earn credit for the Health Information Exchange (HIE) Objective. ECs can meet the objective requirements through the following three options:

- Report on both the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure,
- Report on the HIE Bi-directional Exchange measure, or
- Report on the proposed Enabling Exchange Under TEFCA measure.

In addition to attesting "yes/no" to active engagement, CMS will require ECs to report their level of active engagement for the measures within the Public Health and Clinical Data Registry Reporting Objective.

CMS finalized modifications the point allocations to accommodate some of the new policies within the promoting interoperability category.

Finally, CMS will allow voluntary reporting of the promoting interoperability category for Alternative Payment Model (APM) Entities. APM Entities that do not choose this new reporting option will continue to be scored using the existing roll-up calculation.

MIPS Final Score

Beginning with the 2023 performance year, CMS will score administrative claims measures using data from the current performance period. This new policy does not impact the existing policies regarding establishing historical benchmarks for other quality measures, case minimums, and measures for which no benchmark can be calculated.

CMS finalized its proposal to use the calendar year 2019 MIPS payment year as the prior period for the purposes of establishing the 2025 payment year performance threshold.

As previously finalized, the MIPS performance threshold is 75 points. There is no exceptional performance threshold as the funding for the exceptional performance adjustment ended with the 2022 performance year.

Public Reporting

Beginning in 2023, CMS finalized the addition of a telehealth indicator to the Medicare Compare Tool. It will be added to clinician and group pages. CMS also finalized the addition of a procedural utilization data to the Compare Tool, beginning no earlier than the 2023 calendar year.

Advanced APMs

CMS finalized its proposal to permanently establish the generally applicable revenue-based nominal amount standard at eight percent of the average estimated total Medicare Parts A and B revenue of all providers and suppliers participating in APM entities for the Qualifying Participant (QP) performance period.

CMS finalized an amendment to the 50-clinician limit for APM Entities participating in Medical Home Models. CMS will apply the limit directly to the APM Entity rather than the parent organization of the APM Entity. However, the APM Entity must remain below the 50-clinician limit for all three determination dates during the QP Performance Period.