

Summary of the CY 2023 Medicare Physician Fee Schedule proposed rule

On July 7, 2022, the Centers for Medicare & Medicaid Services (CMS) released the CY 2023 Medicare Physician Fee Schedule (MPFS) proposed rule. This regulation also impacts the Quality Payment Program (QPP). CMS also released accompanying fact sheets on the [MPFS](#), [Medicare Shared Savings Program](#), and QPP proposals. Comments on the proposed rule are due by September 6, 2022. The AAFP will thoroughly review the proposed rule and provide comments to CMS. The final rule will be released around November 1, 2022, and will take effect on January 1, 2023, except where specified otherwise in the final rule.

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

The proposed conversion factor for 2023 is \$33.08. This is 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 proposals to increase relative value units in the rule.

Evaluation and Management (E/M) Visits

CMS is proposing 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. At the same time, CMS is proposing to maintain the current billing policies that apply to the E/Ms while they consider potential revisions that might be necessary in future rulemaking.

CMS is also proposing 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.

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 data from 2006. CMS proposes to rebase and revise the MEI based on a methodology that uses publicly available data sources for input costs that represent all types of physician practice ownership; that is, not limited to only self-employed physicians. Specifically, CMS proposes to use the 2017 U.S. Census Bureau's Services Annual Survey (SAS) data from Table 5, Estimated Selected Expenses for Employer Firms for NAICS 6211 (Office of Physicians). CMS proposes to use the 2017 SAS data for the proposed 2017-based MEI because it is the most recently available and complete data. CMS proposes to supplement the 2017 SAS expense data by using several data sources for further disaggregation of compensation costs and all other residual costs, including:

- the 2017 Bureau of Labor Statistics (BLS) Occupational Employment and Wage Statistics (OEWS)
- the 2012 Bureau of Economic Analysis (BEA) Benchmark Input-Output data(I/O)
- The 2006 AMA PPIS

- The 2020 AMA Physician Practice Benchmark Survey

Using the new MEI cost weights to set PFS rates would not change overall spending on PFS services but would likely result in significant changes to payments among PFS services. In the interest of ensuring payment stability, CMS proposes not to use the proposed updated MEI cost share weights to set PFS payment rates for CY 2023 but is seeking comments on their use in the future.

Determination of Practice Expense Relative Value Units (PE RVUs)

As usual, CMS proposes refinements to the direct practice expense inputs for specific codes. These refinements include updating the price of eight supplies and two equipment items and the pricing of three clinical labor types.

In this proposed rule, CMS signals its intent to move to a standardized and routine approach to valuation of indirect PE. In this context, CMS seeks comment on how it should update indirect PE.

Finally, CMS solicits comments on strategies for improving global surgical package valuation.

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 be included through the end of CY 2023. CMS may revisit the policy if the COVID-19 public health emergency (PHE) extends well into CY 2023.

Following successful AAFP advocacy, and to implement the telehealth extensions enacted by Congress, CMS proposes to continue to allow certain telehealth services that would otherwise not be available via telehealth after the expiration of the PHE to remain on the Medicare Telehealth Services List for 151 days after the expiration of the PHE. CMS also proposes to continue several other policies for 151 days after the expiration of the PHE, including:

- Paying for services included on the TH List as of March 15, 2022, that are furnished in an audio-only telecommunications system
- Reporting TH services using the POS that would have been used had the service been provided in-person.

CMS is also delaying the in-person requirements for mental health visits furnished by rural health clinics (RHCs) and federally qualified health centers (FQHCs).

For TH services provided on 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). Payment for TH services using POS 02 or POS 10 would be made at the PFS facility rate.

Services provided using audio-only communications technology should include modifier -93. This would apply only to services for which use of audio-only technology is permitted. CMS proposes to require RHCs, FQHCs, and opioid treatment programs to use modifier -93 for audio-only services furnished under the PFS. 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.

CMS believes statute requires that telehealth services be so analogous to in-person care that the telehealth service is essentially a substitute for a face-to-face encounter. CMS reiterates that they do

not view audio-only telephone E/M services as analogous to or a substitute for face-to-face services. CMS is not proposing to keep telephone E/M services (CPT codes 99441-99443) on the Medicare Telehealth Services List after the end of the PHE and the 151-day post-PHE extension period. Following the extension period, CMS will assign the codes a “bundled” status. The AAFP continues to advocate for permanent coverage and payment for audio-only telehealth services after the end of the PHE.

CMS is proposing to add several emotional/behavior assessment, psychological, and neuropsychological testing and evaluation services to the TH List on a Category 3 basis. If finalized, CMS intends to add the new prolonged services codes (HCPCS codes GXXX1, GXXX2, and GXXX3) to the TH List on a Category 1 basis.

CMS is not making any proposals related to direct supervision but points out that the pre-PHE rules for direct supervision will resume after December 31 of the year in which the PHE ends.

CMS proposes to set the payment amount for the originating site fee (HCPCS code Q3014) at \$28.61. The final amount will be based on the historical data through the second quarter of 2022 and the most recently available total factor productivity data.

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): CMS proposes the RUC-recommended work RVU for all six codes in the Immunization Administration family. CMS also proposes the RUC’s recommended direct PE inputs (with minor refinements) for these vaccine administration services. However, CMS continues to seek additional information from commenters that specifically identifies the resource costs and inputs that should be considered to establish payment for these vaccine administration services on a long-term basis, consistent with CMS policy objectives for ensuring maximum access to immunization services.

Code Descriptor Changes for Annual Alcohol Misuse and Annual Depression Screenings (HCPCS codes G0442 and G0444): As requested by the AAFP, CMS proposes to modify 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 GYYY1, and GYYY2): CMS proposes to create separate coding and payment for chronic pain management (CPM) services beginning January 1, 2023. Specifically, CMS proposes to create two HCPCS G-codes to describe monthly CPM services as follows:

- HCPCS code GYYY1: 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. (When using GYYY1, 30 minutes must be met or exceeded.)

- HCPCS code GYYY2: 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 GYYY1). (When using GYYY2, 15 minutes must be met or exceeded.)

CMS proposes to value codes GYYY1 and GYYY2 based on a crosswalk to the principal care management codes 99424 and 99425, respectively.

Proposed Revisions to the “Incident to” Physicians’ Services Regulation for Behavioral Health Services: To improve access to behavioral health services, proposing to 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 proposes to create a code describing general behavioral health integration performed by clinical psychologists or clinical social workers on a monthly basis. CMS also proposes to allow general supervision for this service.

Geographic Practice Cost Indices (GPCI)

As required by law, CMS proposes to update the GPICs 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 GPICs, CMS proposes to 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 proposed rule.

Medicare Part B Payment for Preventive Vaccine Administration Services

Consistent with the AAFP’s advocacy, CMS proposes to annually update payment amounts for Part B vaccine administration based upon the increase in the MEI and adjust for geography. CMS also proposes to continue the additional payment for at-home COVID-19 vaccination in CY 2023.

Medicare Parts A and B Payment for Dental Services

CMS is proposing to codify that payment can be made under Medicare Part A and Part B for dental services that are closely linked to or required for an otherwise covered medical service; includes both inpatient and outpatient settings, ancillary services, and other facility services. CMS is seeking comment on other dental services that are inextricably linked to other covered services and should be automatically included under this rule.

Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers

CMS proposes to reduce the minimum age for colorectal cancer screening tests from 50 to 45 years of age for certain Medicare covered screening tests. CMS also proposes to expand coverage of colorectal cancer screening to include a follow-on screening colonoscopy after a non-invasive stool-based test returns a positive result. This would remove beneficiary cost-sharing requirements and Medicare would pay for the entirety of these services.

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

CMS proposes to update the pricing for the methadone weekly bundle and the add-on code for take-home supplies of methadone. CMS proposes to update payment for the drug component to account for inflation. The proposed CY 2023 methadone payment amount would be \$39.29, which is the CY 2022 payment amount of \$37.38 increased by a projected 5.1 percent growth in the Producer Price Index for Pharmaceuticals for Human Use (Prescription) from CY 2021 to CY 2023.

CMS proposes to slightly increase the payment rate for the non-drug component of the bundled payment and apply MEI updates to determine the payment amount.

Consistent with AAFP advocacy, CMS proposes 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 telecommunications technology to initiate treatment with buprenorphine is authorized by the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) at the time the service is furnished.

CMS also proposes to permit the use of audio-only communication technology to initiate treatment with buprenorphine in cases where audio-video technology is not available to the beneficiary.

CMS clarifies that OTPs are able to bill Medicare for medically reasonable and necessary services furnished via mobile units in accordance with SAMHSA and DEA guidance.

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 instead proposes to instead use current year data as soon as it is available to evaluate EPCS compliance

CMS also proposes to determine whether a prescriber qualifies for the emergency or disaster exception based on the prescriber's valid address in PECOS (Medicare Provider Enrollment, Chain, and Ownership System), instead of the NCPDP Pharmacy Database address, and for prescribers who are not enrolled or do not have a valid PECOS address, CMS proposes to use the address in the National Plan and Provider Enumeration System (NPPES) data.

Starting in CY 2025, CMS plans to 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 proposes to make certain conforming changes in the regulations related to the data reporting and payment requirements. Specifically, CMS proposes to update the

definitions of both the “data collection period” and “data reporting period,” specifying that for the data reporting period of January 1, 2023, through March 31, 2023, the data collection period is January 1, 2019, through June 30, 2019. CMS also proposes to revise its regulations to indicate that initially, data reporting begins January 1, 2017, and is required every 3 years beginning January 2023. In addition, CMS proposes to make conforming changes to its requirements for the phase-in of payment reductions to reflect the amendments in the law. Specifically, CMS proposes to indicate that for CY 2022, payment may not be reduced by more than 0.0 percent as compared to the amount established for CY 2021, and for CYs 2023 through 2025, payment may not be reduced by more than 15 percent as compared to the amount established for the preceding year. As a result, the CYs 2022 and 2023 CLFS payment rates for CDLTs that are not ADLTs are based on applicable information collected in the data collection period of January 1, 2016, through June 30, 2016. Under current law, the CLFS payment rates for CY 2024 through CY 2026 will be based on applicable information collected during the data collection 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.

Medicare Shared Savings Program (MSSP)

CMS proposes to make 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: CMS proposes incorporating an option into the Shared Savings Program to make advance shared savings payments to Accountable Care Organizations (ACOs) that are low revenue, inexperienced with performance-based risk Medicare ACO initiatives, new to the Shared Savings Program, and serve underserved populations. 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 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 eliminate barriers to participation, CMS proposes to revise its participation options. Certain ACOs that enter the BASIC track Level A will be eligible to remain in Level A for the entirety of their agreement period (i.e., five years). Additionally, ACOs considered inexperienced with performance-based risk will be allowed to participate in two agreement periods under the BASIC track. CMS also proposes to allow ACOs experienced with performance-based risk to participate in BASIC track Level E or the ENHANCED track indefinitely. CMS would no longer require all ACOs to advance to the ENHANCED track.

Quality: CMS proposes to 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 shared savings. If an 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 will be eligible to share in savings at a rate that reflects the ACO’s quality score.

CMS is proposing a similar policy for determining an ACO’s shared loss rate. 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 proposes to extend the incentive for reporting via eCQMs/Merit-based Incentive Payment System Clinical Quality Measures (MIPS CQMs) through the 2024 performance year. CMS also proposes to add 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. CMS intends to award higher positive adjustments to ACOs providing higher quality of care to underserved beneficiaries. CMS will use the higher of the proportion of an ACO's beneficiaries that are dually eligible or the proportion of beneficiaries residing in areas of high socioeconomic disadvantage (based on the area deprivation index) to identify ACOs serving larger populations of underserved beneficiaries.

Financing and benchmarking: CMS is proposing 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,
- Reinstating an adjustment for prior savings when establishing benchmarks for renewing and re-entering ACOs,
- Reducing the cap on negative regional adjustments.

CMS is proposing to modify the existing three percent cap on risk score growth. Under the proposal, an ACO's aggregate prospective hierarchical condition category (HCC) risk score would be subject to a cap equal to the ACO's aggregate growth in demographic risk scores between benchmark year three and the performance year, plus three percentage points.

CMS is also proposing to allow certain ACOs participating in the BASIC track that do not meet the minimum savings rate to qualify for shared savings. Under the proposal, an ACO would still need to meet the quality standard or proposed 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 proposes several modifications aimed at reducing administrative burden for SSP participants.

Updates to the Quality Payment Program

MIPs Value Pathways (MVPs)

CMS plans to implement MVPs, a streamlined MIPS reporting option, beginning in CY 2023. CMS proposes modifications to the MVP development process to provide additional opportunities for public feedback. MVPs that are ready for feedback (as determined by CMS) would be posted to the QPP website. Stakeholders would have 30-days to provide input. CMS is also proposing to allow the general public to submit their recommendations for revisions to established MVPs on a rolling basis throughout the year.

For the purposes of MVPs, CMS proposes to define a single specialty group as 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 is proposing five new MVPs:

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

CMS is also proposing modifications to the seven previously established MVPs. For the Optimizing Chronic Disease Management MVP, CMS proposes to include another patient survey measure (Consumer Assessment of Healthcare Providers and Systems [CAHPS] for MIPS) to offer additional options for patient surveys.

Beginning in 2026, multispecialty groups must form subgroups to report MVPs. CMS does not propose any restrictions on the composition of subgroups but may do so in the future. To inform future policies, CMS proposes that tax identification numbers (TINs) must provide a description of each subgroup that it registers. Additionally, CMS proposes that individual eligible clinicians (represented by a TIN-NPI combination) will be limited to one subgroup within the group's TIN. CMS intends to apply the low-volume threshold to subgroups using information from the initial 12-month segment of the applicable MIPS determination period.

MIPS Quality

CMS proposes to modify the definition of a high priority measure to include health equity-related measures. CMS is proposing nine new MIPS quality measures, including a measure to support identification of specific drivers of health associated with inadequate healthcare access and adverse health outcomes. CMS proposes 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 proposes to increase the data completeness criteria threshold to 75 percent for the 2024 and 2025 MIPS performance years.

MIPS Improvement Activities

CMS proposes adding four new improvement activities, modifying five existing activities, and removing six previously adopted activities. The proposed new activities align with the Administration's goal of advancing health equity for all and include:

- Use Security Labeling Services Available in Certified Health Information Technology for Electronic Health Record Data to Facilitate Data Segmentation
- Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients
- Create and Implement a Language Access Plan
- COVID-19 Vaccine Promotion for Practice Staff

MIPS Promoting Interoperability

Beginning with the 2023 performance period, CMS proposes to require MIPS eligible clinicians (ECs) to report the Query of Prescription Drug Monitoring Program (PDMP) measure for the promoting interoperability category. The measure requires reporting a “yes/no” response and would be worth 10 points. CMS also proposes to expand the measure to include Schedule III and IV drugs in addition to Schedule II opioids.

CMS proposes to add a new measure that would allow ECs to earn credit for the Health Information Exchange (HIE) Objective. ECs would be able to 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.

CMS would require ECs to report their level of active engagement for the measures within the Public Health and Clinical Data Registry Reporting Objective. Currently, ECs only attest “yes/no” to being in active engagement with a registry.

CMS proposes to modify the point allocations to accommodate some of the proposals within the promoting interoperability category. Specifically, if the Query of PDMP measure is required, CMS would reduce the points associated with the Health Information Exchange Objective from 40 points to 30 points. CMS also proposes to increase the points allocated to the Public Health and Clinical Data Exchange Objective to 25 points. As a result, CMS would reduce the points for the Provide Patients Electronic Access to Their Health Information to 25 points.

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

MIPS Final Score

In general, CMS calculates quality benchmarks using data from a baseline period that is two years prior to the applicable MIPS performance period. Beginning with the 2023 performance year, CMS proposes to score administrative claims measures using data from the current performance period. This proposal would not impact the existing policies regarding case minimums and measures for which no benchmark can be calculated.

Facility-based ECs were previously ineligible to receive the complex patient bonus. However, CMS proposes to allow facility-based ECs to be eligible for the complex patient bonus, even if they do not submit data for at least one MIPS performance category.

CMS is bound by statute to set the MIPS performance threshold using the mean or median of a prior year’s final scores. CMS previously finalized that they would use the mean final score to determine the performance threshold for MIPS payment years 2024-2026. CMS is proposing to use the calendar year 2019 MIPS payment year as the prior period for the purposes of establishing the 2025 payment year performance threshold.

For the 2023 performance year/2025 payment year, the MIPS performance threshold will be 75 points. ECs with a final score of 75 will receive a neutral payment adjustment. ECs with a final score greater than or equal to 75.01 will be eligible for a positive payment adjustment based on a linear sliding scale. ECs with a final score below 75 will receive a negative payment adjustment based on a sliding scale. ECs in the bottom quartile (final score of 18.75 or below) will receive the maximum -9 percent payment adjustment in the 2025 MIPS payment year.

There is no exceptional performance threshold as the funding for the exceptional performance adjustment ended with the 2022 performance year.

Public Reporting

CMS proposes to add a telehealth indicator to the Medicare Compare Tool. It would be added to clinician and group pages. CMS would identify clinicians who perform TH services using claims data (POS 02 or modifier -95) and use a six-month lookback period. They would update the pages bi-monthly. CMS also proposes to add procedural utilization data to the Compare Tool, beginning no earlier than the 2023 calendar year. CMS would use a 12-month lookback period and update bi-monthly.

Advanced APMs

CMS proposes to clarify that the quality measurement requirement for AAPMs may be met using a single quality measure that meets both criteria. The measure would need to be endorsed by a consensus-based entity or determined by CMS to be evidence-based, reliable, and valid, and must be an outcome measure.

CMS also proposes 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 is proposing to amend the 50-clinician limit for APM Entities participating in Medical Home Models. CMS would 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. If the APM Entity exceeds the limit, the Medical Home Model financial risk and nominal amount standards would not apply, and no ECs would achieve or retain QP status for the corresponding payment year.

Per statute, for performance year 2023, the QP thresholds for the Medicare Option will be 75 percent for the payment amount method and 50 percent for the patient count method. The partial QP thresholds will be 50 percent and 35 percent for the payment and patient count methods, respectively.

The QP thresholds for the All-Payer Combination Option align with the Medicare Option. ECs must first meet certain thresholds under the Medicare Option to be considered a QP under the All-Payer Combination Option. The Medicare Option threshold is 25 percent for the payment amount method and 20 percent for the patient count method.