Medicare Physician Fee Schedule: 2023 Final Rule

December 15, 2022

2:00 pm EST

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Agenda

- **Appropriate Use Criteria Program Update**
- **Reimbursement Proposals**
  - Conversion Factor
  - Colorectal Cancer Screenings
- **Physician Supervision**
- **Evaluation and Management (E&M) Split Visits**
- **Telehealth**
- **Quality Payment Program (QPP)**
  - Merit-based Incentive Payment Program (MIPS)
  - MIPS Value Pathways MVPs
  - Advanced APMs

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Appropriate Use Criteria Update

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AUC Update

The **2023 rule** did not contain any information on the Appropriate Use Criteria program but….we did get this notice on the official CMS website:

NOTICE: The payment penalty phase will not begin January 1, 2023 even if the PHE for COVID-19 ends in 2022.

Until further notice, the educational and operations testing period will continue. CMS is unable to forecast when the payment penalty phase will begin. There is no new timeline for the program available at this time.

- As of now, PHE *anticipated* to last until ~April of 2023

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Reimbursement Updates

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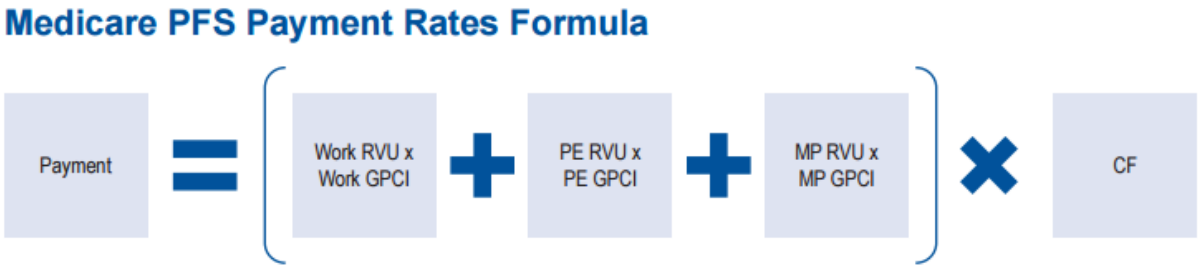
Reimbursement Updates

The **conversion factor (CF)** is a multiplier used by **Medicare** applied to relative value units (RVUs) to calculate reimbursement for a particular service using the following formula:



- Updates to the CF apply to ***all*** procedures paid by Medicare
- Updates to RVUs apply to specific procedures

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Reimbursement Updates

- **2023 Final Conversation Factor**

2022 Final* CF		**$34.61**
***This is the 2022 CF of 33.59 + 3% increase from Protecting Medicare and American Farmers from Sequester Cuts Act.**		
Statutory Update	***0%***	
2023 Budget Neutrality Adjustment	***-1.55%***	
2023 Final Conversion Factor		**$33.06**
2022 to 2023 Difference		**-1.55**
2022 to 2023 % Difference		**~-4.48%**

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Reimbursement Updates

- **2023 Final Anesthesia CF**

2022 Final* Anesthesia CF		**$21.56**
***This is the 2022 CF of 33.59 + 3% increase from Protecting Medicare and American Farmers from Sequester Cuts Act.**		
Statutory Update	***0%***	
2023 Budget Neutrality Adjustment	***-1.55%***	
2023 PE and Malpractice Adjustment	***.53%***	
2023 Final Conversion Factor		**$20.60**
2022 to 2023 Difference		**-.96**
2022 to 2023 % Difference		**~-4.42%**

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Reimbursement Updates

- **What's behind these decreases?**

  - **2021 Evaluation and Management (E&M) Overhaul**
    - CMS revised requirements for code selection and increased RVUs for patient office visit codes
    - This would have initially resulted in ~10% cuts towards specialties in *2021*
    - Consolidated Appropriations Act (CCA) delayed the use of one e/m code for 3 years and added +3.75% ($3 Billion) to CF

  - **2022 Clinical Labor (PE RVU) Pricing Update**
    - CMS opted to phase in labor pricing updates over 4 years

  - **Protecting Medicare and American Farmers from Sequester Cuts Act**
    - 3% increase to CF expiring at the end of this year

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Reimbursement Updates

- **Real world impact of fee schedule proposals will vary greatly by case-mix and location**
  - EX – facility vs non-facility

- **Additional Non-Fee Schedule Medicare Cuts to Keep in Mind**
  - **-2% Sequester cut fully resumed July 1st 2022**
  - **-4% PAYGO cut delayed until 2023**
    - Requires congressional intervention to waive budget control requirement triggered by CCA

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Reimbursement Updates

- **Keep an eye out for possible congressional intervention for relief**

- **Supporting Medicare Providers Act, H.R. 8800**
  - **Introduced in September, still in committee**
  - **Garnering attention in news cycle**

- **No legislation addressing PAYGO yet**

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Reimbursement Updates

- **Colorectal Cancer Screening Coverage**
  - CMS has finalized update to align coverage of colorectal cancer screens with revised USPSTF recommendations
    - Lowers eligibility age from 50 to 45
  - Definition of colorectal cancer screening to include a follow-on screening colonoscopy **after** a positive result on a Medicare covered non-invasive stool-based screening test.
    - Colonoscopy will be 100% covered after positive non-invasive result – no patient cost sharing

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Physician Supervision

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Physician Supervision

- **Level 2 Physician Supervision Via Audio/Video Communication**

CMS announced that there will **not** be an extension of current PHE flexibility to allow physicians to provide level 2 supervision via audio/video communication.

After December 31 of the year in which the PHE ends, the pre-PHE rules for direct supervision will apply.

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Evaluation and Management (E&M)
Split Visits

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Evaluation and Management (E&M)

CMS has ***delayed*** the split (or shared) visits policy finalized in CY 2022 for the definition of the substantive portion of an e/m visit

The substantive portion of a visit may be met by any of the following elements in ***2023***:

- History.
- Performing a physical exam.
- Making a medical decision.
- Spending time (more than half of the total time spent by the practitioner who bills the visit)

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Telehealth

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Telehealth

Many CMS policies for TeleHealth codify requirements of the Consolidated Appropriations Act of 2022 (CCA) within the fee schedule for 2023 to preserve flexibilities for **151 days beyond** the end of the public health emergency, specifically:

- Allowing telehealth services to be furnished in any geographic area and in any originating site setting, including the beneficiary's home
- Allowing certain services to be furnished via audio-only telecommunications systems
- Extend the duration of temporary codes on the CMS telehealth list for 151 days beyond end of PHE
- Delays the in-person visit requirements for mental health services furnished via telehealth until **152** days after the end of the PHE.

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Telehealth

- **CMS finalized using PLACE OF SERVICE indicator to indicate telehealth encounters *after* 151 days following the end of the PHE**
  - Modifier 95 has been used during PHE due to location related waivers
- **Modifier 93 will be used for identifying audio-only encounters *after* 151 days following the end of the PHE**

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Quality Payment Program

Merit-based Incentive Payment System (MIPS)

Advanced APMs

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Quality Payment Program

<u>No</u> changes have been proposed to basic program eligibility

- **Providers who exceed all three of the following as ***<u>an individual</u>*** must participate in QPP:**
  - **$90,000+ Medicare part B allowed charges**
  - **200+ Medicare covered services**
  - **200+ Medicare beneficiaries**

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Quality Payment Program - MIPs

<u>No</u> changes have been proposed to category weights or performance thresholds, the 2023 performance period will maintain the following:

- **Penalty Threshold: 75 points**
- **Exceptional Performer Threshold: No longer available**
- **Maximum Payment Adjustment: +/- 9%**

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Quality Payment Program - MIPs

2022 Policy Reminders in place for 2023:

- **Small Practices – groups of 15 or fewer clinicians qualify for special weighting if not scored on COST or Promoting Interoperability**
  - ***50% Quality and 50% Improvement Activity***

- **3 Point Floor for Quality Removed**
  - Measures *without* a benchmark will return 0 points
  - Measures with a benchmark that also meet case minimum (20) and data completeness (70%) requirements will return 2 or 1 points depending on benchmarks

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Quality Payment Program - MIPs

2022 Policy Reminders in place for 2023:

- **Complex patient bonus permanently expanded to 10 points, attribution methodology changed**
- **High Priority/End to End Bonus Points Removed**
- **Higher Point Floors for NEW Quality measures**
  - Measures new to MIPs will earn minimum of 7 points first year, 5 points second

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Quality Payment Program - MIPs

Quality Category Updates

- **Data Completeness rate proposed to increase to 75% for 2024 and 2025**
  - *Data Completeness requirements will remain at 70% for 2023*

  - *Added **9** new Quality Measures*
  - *Modified **75** existing Quality Measures*
  - *Removed **15** existing Quality measures*

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Quality Payment Program - MIPs

Quality Measures Removed	
76	**Prevention of Central Venous Catheter (CVC) - Related Bloodstream Infections**
110	**Preventive Care and Screening: Influenza Immunization**
111	**Pneumococcal Vaccination Status for Older Adults**
119	Diabetes: Medical Attention for Nephropathy
258	Rate of Open Repair of Small or Moderate Non-Ruptured Infrarenal Abdominal Aortic Aneurysm
260	Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications
261	Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness
265	**Biopsy Follow-Up**

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Quality Payment Program - MIPs

Quality Measures Removed	
275	Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy
323	**Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention**
375	Functional Status Assessment for Total Knee Replacement
425	Photodocumentation of Cecal Intubation
439	Age Appropriate Screening Colonoscopy
455	Percentage of Patients Who Died from Cancer Admitted to the Intensive Care Unit (ICU) in the Last 30 Days of Life
460	Back Pain After Lumbar Fusion
469	Functional Status After Lumbar Fusion

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Quality Payment Program - MIPs

New Measures Added

- **Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System *(Administrative claims-based)***
- **Adult Immunization Status – replacement for 110/111**
- **Screening for Social Drivers of Health (added to all specialty sets)**
- **Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma**
- **Dermatitis – Improvement in Patient-Reported Itch Severity**
- **Psoriasis – Improvement in Patient-Reported Itch Severity**
- **Appropriate Intervention of Immune-Related Diarrhea and/or Colitis in Patients Treated with Immune Checkpoint Inhibitors**
- **Kidney Health Evaluation**

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Quality Payment Program - MIPs

Promoting Interoperability

- **Shifting maximum point values for category objectives**
  - Immunization Registry Reporting and Electronic Case Reporting increased from 10 to 25 points
  - Points lowered for other measures
- **Query of Prescription Drug Monitoring Program (PDMP) measure no longer bonus/optional**
- **Adding 3rd measure to Health Information Exchange (HIE) Objective**
  - Participation in the Trusted Exchange Framework and Common Agreement (TEFCA)

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Quality Payment Program - MIPs

Cost Updates

- **Cost improvement bonus added to category**

Improvement Activities

- *Added **4** new activities*
- *Removal of **6** existing activities*

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Quality Payment Program - MIPs

Improvement Activities Removed	
IA_BE_7	Participation in a QCDR, that promotes use of patient engagement tools
IA_BE_8	Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive
IA_PM_7	Use of QCDR for feedback reports that incorporate population health
IA_PSPA_6	Consultation of the Prescription Drug Monitoring Program
IA_PSPA_20	Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes
IA_PSPA_30	PCI Bleeding Campaign

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Quality Payment Program - MVPs

MIPS VALUE PATHWAYS (MVPS)

- **MVPs are a new reporting framework for MIPS beginning in 2023 which will eventually replace 'traditional MIPs'**

- **Instead of choosing measures/activities out of ALL available, an MVP providers a specific list to select from**

- **Data submission is automated wherever possible and reporting burden reduced**
  - Participants report 4 quality measures, fewer improvement activities

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Quality Payment Program - MVPs

5 New MVPs have been added for the 2023 Performance Year:

1. Advancing Cancer Care
2. Optimal Care for Kidney Health
3. Optimal Care for Patients with Episodic Neurological Conditions
4. Supportive Care for Neurodegenerative Conditions
5. Promoting Wellness

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Quality Payment Program - AAPM

Advanced Alternative Payment Models (AAPM)

- CMS has **removed** the 2024 expiration of the **8% minimum on the Generally Applicable Nominal Risk standard** for Advanced APMs and has made the 8% minimum permanent
  - This is the minimum percentage of financial risk to be considered an **'Advanced'** APM

- CMS requested information on how to best implement AAPM conversation factor bonus for 2024
  - **5% APM Incentive payment no longer available after this year – possible congressional intervention tacked on to end of year legislation**

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Summary

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Summary

- **2023 Reimbursement updates**
  - Multiple cuts looming: CF decrease, PAYGO

- **Quality Payment Program**
  - Difficult year ahead for larger groups
    - Additional COVID flexibilities unlikely
  - First year for MVPs!
  - AAPMs – no 5% incentive for 2023

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Questions?

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