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CMS Issues Proposed CY2023 Medicare Physician Fee Schedule

Proposals aim for "whole-person" care, enhanced access to behavioral health and preventative services paired with overarching payment cut for physician services.

Last Thursday (July 7), the Centers for Medicare & Medicaid Services (CMS) issued their Calendar Year (CY) 2023 Medicare Physician Fee Schedule (MPFS) Proposed Rule. The rule includes proposals intended to expand access to behavioral health services, cancer screening, and dental care — particularly in rural and underserved areas – as well as proposals advancing health equity and high-quality, whole-person care through care coordination and additional participation in Accountable Care Organizations (ACOs). "At CMS, we are constantly striving to expand access to high quality, comprehensive health care for people served by the Medicare program," said CMS Administrator Chiquita Brooks-LaSure. "[These] proposals expand access to vital medical services like behavioral health care, dental care, and cancer treatment options, all while promoting access, innovation, and cost savings in the Medicare program."

Among the proposed policies, CMS proposes changes to ACO benchmarks and metrics to sustain long-term participation and reward provision of care for underserved populations, also proposing payment flexibilities for certain ACOs to address patients' social needs. Other policies includes those to enable additional non-physician professionals to provide general mental health care and bolster provision of opioid treatment from mobile vans, expand preventative service coverage for colonoscopies, broaden Medicare's narrow dental coverage definition, and expand access to audiology and chronic pain management services. CMS also proposes to delay the split (or shared) Evaluation and Management (E/M) visits policy finalized in CY 2022 to define the substantive portion of a visit based on the amount of time spent by the billing practitioner.

The rule also includes a 4.42 percent reduction of the conversion factor, the starting point for calculating Medicare payments for physician services. The conversion factor accounts for a statutorily required budget neutrality adjustment and the expiration of a 3 percent increase in physician payments for 2022 that was required by the Protecting Medicare and American Farmers from Sequester Cuts Act (S. 610). Provider groups are already pushing back on the proposed cuts. Jack Resneck, president of the American Medical Association (AMA) said in a statement that "the rule not only fails to account for inflation in practice costs and COVID-related challenges to practice sustainability, but also includes a significant and damaging across-the-board reduction in payment rates." Similarly, the Surgical Care Coalition said the cuts "threaten patient care and are unsustainable for the long term."

Comments are due September 6, 2022.

For more information, see:

- Fact Sheet: Calendar Year (CY) 2023 Medicare Physician Fee Schedule Proposed Rule
- Fact Sheet: CY 2023 Quality Payment Program proposed changes
- Fact Sheet: Proposed Medicare Shared Savings Program changes
- CMS blog: Strengthening Behavioral Health Care for People with Medicare
- Press release: CMS Proposes Physician Payment Rule to Expand Access to High-Quality Care

Summary of Key Provisions (Non-Comprehensive)

Conversion Factor: The proposed CY 2023 PFS conversion factor is $33.08, a decrease of $1.53 to the CY 2022 PFS conversion factor of $34.61. This conversion factor accounts for the statutorily required update to the conversion factor for CY 2023 of 0 percent, the expiration of the 3 percent increase in PFS payments for CY 2022 as required by the Protecting Medicare and American Farmers From Sequester Cuts Act, and the statutorily required budget neutrality adjustment to account for changes in Relative Value Units.

Updated Medicare Economic Index (MEI) for CY 2023: CMS is proposing to rebase and revise the MEI cost share weights. CMS outlines a new methodology for estimating base year expenses that relies on publicly available data that are more reflective of current market conditions and will allow for the MEI to be updated on a more regular basis. Given the potential for the new MEI cost weights to result in significant changes to payments among PFS services, CMS is proposing not to use the proposed updated MEI cost share weights to set PFS payment rates for CY 2023 but is soliciting comment for its future use.

Evaluation and Management (E/M) Visits: CMS is proposing to adopt most of the revised coding and updated guidelines for Other E/M visits approved by the AMA CPT Editorial Panel effective January 1, 2023. CMS is also proposing to delay the split (or shared) visits policy finalized in CY 2022 to define the substantive portion of a split (or shared) visit based on the amount of time spent by the billing practitioner.

Medicare Shared Savings Program (MSSP): Changes to the MSSP, which are aimed at advancing CMS' overall value-based care strategy of growth, alignment and equity include:

- Modifying the manner in which benchmarks are calculated in an effort to help sustain long-term participation, including reducing the impact of ACOs' performance on their benchmarks. CMS is also seeking comment on an alternative approach to calculating ACO historical benchmarks that would use administratively set benchmarks that are decoupled from ongoing observed fee-for-service (FFS) spending.
- Making advanced shared savings payments to new, low-revenue ACOs that serve underserved populations, which can use the funds to hire, could use the funds upfront to hire behavioral health practitioners and address the social needs of people with Medicare, such as food and housing.
- Other modifications to existing policies under MSSP to allow certain new ACOs greater flexibility in the progression to performance-based risk.
- Updates to MSSP quality-measurement policies, including a new health equity adjustment and policies aimed at supporting the transition of ACOs to all-payer quality measure reporting.

Mental and Behavioral Health: Policies aimed at bolstering the behavioral health workforce, which include:

- Creating a new a new General behavioral health integration (BHI) service personally performed by clinical psychologists (CPs) or clinical social workers (CSWs) to account for monthly care integration where the mental health services furnished by a CP or CSW are serving as the focal point of care integration.
- Creating an exception to supervision requirements, allowing marriage and family therapists, licensed professional counselors, addiction counselors, certified peer recovery specialists, and others to provide behavioral health services while being under general supervision rather than "direct" supervision.

- Asking for feedback on how Medicare should cover intensive behavioral health management in community-based settings.
- Policies directed at Opioid Treatment Programs (OTPs), including revising the methodology for pricing the drug component of the methadone weekly bundle and add-on code for take-home supplies; allowing the OTP intake add-on code to be furnished via two-way audio-video communications technology (or audio-only in certain circumstances) when billed for the initiation of treatment with buprenorphine; and enabling OTPs to bill Medicare for services performed by mobile units, such as vans, without obtaining a separate registration.

Quality Payment Program (QPP): Proposals are focused on continuing to develop new MIPS Value Pathways (MVPs) and refining the subgroup participation option, including:

- Five new, optional MVPs that would be available beginning in 2023.
- Proposing refinements to the MIPS subgroup reporting process, an increase to the quality data completeness threshold, and changes to the requirements and scoring of the Promoting Interoperability category.
- Removing duplicative and topped out measures, as well as those with limited adoption.
- Several policies aimed at reducing burden and facilitating participation in Alternative Payment Models (APMs), including permanently establishing the 8 percent minimum Generally Applicable Nominal Risk standard for Advanced APMs, which is currently set to expire in 2024.
- Requests for input on policy ideas for advancing health equity, transitioning to digital quality measurement, and the future of the QPP.

Telehealth: Proposals related to Medicare telehealth services including temporarily expanding services provided during the Public Health Emergency (PHE). This includes:

- Making several services that are temporarily available as telehealth services for the PHE available through CY 2023 on a Category III basis, allowing more time for collection of data that could support their eventual inclusion as permanent additions to the Medicare telehealth services list.
- Extending the duration of certain temporary telehealth services for a period of 151 days following the end of the PHE, in alignment with the Consolidated Appropriations Act, 2022.
- Proposing to implement the telehealth provisions in the CAA, 2022 via program instruction or other sub-regulatory guidance to ensure a smooth transition after the end of the PHE.

Dental, Oral and Audiology Services: Proposals to broaden Medicare's dental coverage definitions and expand access to audiology services, including:

- Paying for dental services not currently covered by Medicare, such as dental examination and treatment preceding an organ transplant. CMS is also seeking comment on other medical conditions where Medicare should pay for dental services, such as cancer treatment or joint replacement surgeries.
- Clarifying and codifying certain aspects of Medicare FFS payment polices for dental services and requesting additional comment on other changes and potential future payment models for dental and oral health care services.
- Allowing beneficiaries to have direct access, when appropriate, to an audiologist without a physician referral by creating a new HCPCS code (GAUDX) for audiologists to use when billing for audiology services they already provide.

Chronic Pain Management Services: Proposals aimed at facilitating payment for medically necessary chronic pain management services, including new HCPCS codes and valuation for chronic pain management and treatment services (CPM) for CY 2023. The proposed codes include a bundle of services furnished during a month for holistic chronic pain care, aligned with similar bundled services in Medicare.

Colorectal Cancer Screening: Proposals aimed at reducing barriers to getting a colonoscopy, including considering a follow-up colonoscopy to an at-home test as a preventive service, which means Medicare cost-sharing would be waived, and covering the service for individuals 45 years of age and above, in line with the newly lowered age recommendation (down from 50) from the United States Preventive Services Task Force.

For additional information or questions, please contact Heather Meade or Laura Dillon.