Calendar Year (CY) 2023 Medicare Physician Fee Schedule Proposed Rule

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Fiscal Year 2023 Medicare Physician Fee Schedule Proposed Rule

- On July 7, 2022, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that announces and solicits public comments on proposed policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, effective on or after January 1, 2023.

Background on the Physician Fee Schedule

- Payments are based on the relative resources typically used to furnish the service. Relative value units (RVUs) are applied to each service for work, practice expense, and malpractice expense. These RVUs become payment rates through the application of a fixed-dollar conversion factor. Geographic adjustments (geographic practice cost index) are also applied to the total RVUs to account for variation in practice costs by geographic area. Payment rates are calculated to include an overall payment update specified by statute.

E&M Services CY2023 PFS Proposals

- AMA CPT Editorial Panel approved updated coding and documentation Other E/M visits, effective 1/1/2023
- Similar to CY 2021 PFS final rule for office/OP E/M visits, proposing to adopt most of these changes
- Other E/M visits changes (which include hospital inpatient, hospital observation, emergency department, nursing facility, home or residence services, and cognitive impairment assessment) would be effective 1/1/2023
- Revised framework would include:
  - New descriptor times (where relevant).
  - Revised interpretive guidelines for levels of medical decision making.
  - Choice of medical decision making or time to select code level (except for a few families like emergency department visits and cognitive impairment assessment, which are not timed services).
  - Eliminated use of history and exam to determine code level (instead there would be a requirement for a medically appropriate history and exam).
- Proposing to maintain the current billing policies that apply to the E/Ms while we consider future revisions
- Proposing Medicare-specific coding for payment of Other E/M prolonged services, similar to CY 2021 PFS

Split (or Shared) E/M Visits

- Proposes to delay the split (or shared) visits policy finalized in CY 2022 for the definition of substantive portion, as more than half of the total time, for one year with a few exceptions.

- For CY 2023, as in CY 2022, the substantive portion of a visit may be met by any of the following elements:
  - 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).

Medicare Telehealth Services CY2023 PFS Proposals

- Propose making several temporarily available telehealth services (for the PHE) available through CY 2023 on a Category III basis
- Propose to extend the duration of time that services are temporarily included on the telehealth services list during the PHE, but are not included on a Category I, II, or III basis for a period of 151 days following the end of the PHE, in alignment with the Consolidated Appropriations Act, 2022 (CAA, 2022).
- Propose to implement the telehealth provisions in the CAA, 2022 via subregulatory guidance to ensure a smooth transition after the end of the PHE. These policies extend certain flexibilities in place during the PHE for 151 days after the PHE ends,
  - 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
  - allowing PT, OT, SLP, and audiologists to furnish telehealth services
  - delays the in-person visit requirements for mental health services furnished via telehealth until 152 days after the end of the PHE

Medicare Telehealth Services CY2023 PFS Proposals

- The CAA, 2022 also delays the in-person visit requirements for mental health services furnished via telehealth until 152 days after the end of the PHE.

- Proposes that telehealth claims will require the appropriate place of service (POS) indicator to be included on the claim, rather than modifier "95," after a period of 151 days following the end of the PHE.

- Proposes that modifier "93" will be available to indicate that a Medicare telehealth service was furnished via audio-only technology, where appropriate.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) – Telehealth Services (PFS NPRM)

- Propose to implement the telehealth provisions in the CAA, 2022 via subregulatory guidance to ensure a smooth transition after the end of the PHE. These policies extend certain flexibilities in place during the PHE for 151 days after the PHE ends,
  - allowing payment for RHCs and FQHCs for furnishing telehealth services (other than mental health visits that can be furnished virtually on a permanent basis) under the payment methodology established for the PHE
  - 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
  - delays the in-person visit requirements for mental health visits furnished by RHCs and FQHCs via telecommunications technology until 152 days after the end of the PHE

Behavioral Health Services (PFS NPRM)

- Propose to create a new General BHI service personally performed by 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. We are also proposing to allow a psychiatric diagnostic evaluation to serve as the initiating visit for the new general BHI service.
- Propose regulatory revisions that may help to reduce existing barriers and make greater use of the services of behavioral health professionals, such as licensed professional counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) by making an exception to the direct supervision requirement under our "incident to" regulation at 42 CFR 410.26 to allow behavioral health services provided under the general supervision of a physician or NPP, rather than under direct supervision, when these services or supplies are provided by auxiliary personnel incident to the services of a physician (or non-physician practitioner).

Chronic Pain Management Services (PFS NPRM)

- Propose a 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 that we believe to be the starting point for holistic chronic pain care, aligned with similar bundled services in Medicare, such as those furnished to people with suspected dementia or substance use disorders.
- Proposed elements in the CPM code: diagnosis; assessment and monitoring; use of a pain rating scale or tool; a person-centered care plan; overall treatment management; coordination of behavioral health treatment; medication management; pain and health literacy counseling; chronic pain related crisis care; and ongoing communication and coordination between relevant practitioners furnishing care

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) – CPM and BHI Services (PFS NPRM)

- Propose to add the new chronic pain management and behavioral health integration services to the RHC and FQHC specific general care management HCPCS code, G0511, to align with the proposed changes made under the PFS for CY 2023

Preventive Vaccine Administration Services

- Proposes refinements to the payment amount for preventive vaccine administration under the Medicare Part B vaccine benefit. We are proposing to annually update the payment amount based upon the increase in the Medicare Economic Index (MEI) and to adjust for the geographic locality, based upon the PFS locality where the preventive vaccine is administered using the geographic adjustment factor (GAF).

- Proposes to continue the additional payment for at-home COVID-19 vaccinations for CY 2023.

Colorectal Cancer Screening (PFS NPRM)

- Proposing two Medicare coverage updates to align with recent USPSTF and professional society recommendations.
- Proposing to reduce the minimum age payment limitation to 45 years
- Proposing to expand definition of CRC screening tests to include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.
- Proposals will expand access to quality care and to improve health outcomes for patients through prevention and early detection services, as well as through effective treatments.

Dental and Oral Health Services (PFS NPRM)

- Propose to clarify and codify current Medicare FFS payment policies for dental services
- Propose and seek comment on payment for dental exams and necessary treatments prior to organ transplants, cardiac valve replacements, and valvuloplasty procedures that may be integral to the clinical success of an otherwise covered medical service
- Requesting comments on other types of clinical scenarios where dental services may be integral to the clinical success of clinically related services, or furnished in connection with other covered medical services
- Finally, we are also seeking comment on potential future payment models for dental and oral health care services, and other impacted policies.

Audiology Services (PFS NPRM)

- Propose to allow 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 that are defined by other code(s).
- The service(s) encompassed by the new HCPCS code would be personally furnished by the audiologist and would allow beneficiaries to receive: care for non-acute hearing or assessments unrelated to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids.
- We are proposing to permit audiologists to bill for this direct access (without a referral) once every 12 months.

Quality Payment
PROGRAM

OVERVIEW OF THE 2023 QUALITY PAYMENT PROGRAM PROPOSED RULE POLICIES

Topics

- Future Direction of QPP
- 2023 Proposals for the Quality Payment Program (QPP)
  - MIPS Value Pathways (MVPs) Proposals
  - Merit-based Incentive Payment System (MIPS) Proposals
  - Public Reporting Proposals
  - Advanced Alternative Payment Models (APMs) Proposals
  - Medicare Shared Savings Program Proposals
- Comment Period ended

FUTURE DIRECTION OF THE QUALITY PAYMENT PROGRAM

Quality Payment Program

Future Direction as Outlined in 2023 PFS NPRM

- We recognize the challenges faced by many across the country over the past 2 years. As we look to the future of QPP, **CMS remains committed to promoting more meaningful participation for clinicians, ensuring the policies continue to drive us toward value and improved health outcomes for patients.**

- **To further these goals under MIPS, the 2023 NPRM focuses on:**
  - Continuing to develop new MVPs
  - Refining the subgroup participation option
  - Reducing burden to facilitate participation in APMs

- CMS is proposing limited changes in traditional MIPS to provide clinicians continuity and consistency while they gain familiarity with MVPs.

MVP PROPOSALS

MIPS Value Pathways (MVPs) Proposals

MVP Participation

- As finalized in the Calendar Year (CY) 2022 PFS Final Rule, for MIPS 2023, 2024, and 2025 performance years, CMS defines an MVP Participant as:
  - Individual clinicians
  - Single specialty groups
  - Multispecialty groups*
  - Subgroups
  - APM Entities

*Beginning in the 2026 performance year, multispecialty groups would be required to form subgroups to report to MVPs.

- CMS proposes revising the definitions of single specialty and multispecialty groups to **identify Medicare Part B claims as the data source for determining specialty type**.
  - Specifically, CMS would define a single specialty group as a group that consists of one specialty type as determined by CMS using Medicare Part B claims, and to define a multi-specialty group as a group that consists of 2 or more specialty types as determined by CMS using Medicare Part B claims.

For more information about MVP policies, see the 2023 QPP Proposed Rule Resources.

MIPS Value Pathways (MVPs) Proposals

MVP Candidates

CMS is proposing **5 new MVPs** and revising the **7 previously established MVPs** that would be available beginning with the 2023 performance year:

Proposed MVPs
Advancing Cancer Care MVP
Optimal Care for Kidney Health MVP
Optimal Care for Patients with Episodic Neurological Conditions MVP
Supportive Care for Neurodegenerative Conditions MVP
Promoting Wellness MVP

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

For more information, visit the Explore MVPs webpage

MIPS Value Pathways (MVPs) Proposals

MVP Development

Proposed Additions to MVP Development Process:

- Broaden the opportunities for the public to provide feedback on viable MVP candidates by posting draft versions of MVP candidates on the QPP website to solicit feedback for a 30-day period.
  - CMS would review all feedback and determine if any changes recommended should be incorporated into a candidate MVP before it's proposed in rulemaking.
  - CMS wouldn't consult with the group or organization that submitted the original MVP candidate in advance of rulemaking.
- Clarifying how MVPs can be developed to reflect team-based care and the patient journey by describing how MVPs can involve multiple clinician types that engage with the patient.

Review detailed instructions for MVP candidate development and formally submit MVP candidates for CMS consideration via the MVP Candidate Development & Submission webpage.

MIPS Value Pathways (MVPs) Proposals

MVP Maintenance

Proposed Revisions to MVP Maintenance Process:

- The MVP maintenance process provides interested parties with the opportunity to recommend changes to finalized MVPs for CMS to consider in future rulemaking.
- In the CY2022 PFS Final Rule, CMS finalized the process to solicit recommendations from stakeholders to previously finalized MVPs by **sending an email to CMS detailing the recommended changes for the MVP, by performance category**.
- CMS proposes to **expand opportunities for interested parties to participate in MVP maintenance to include an annual public webinar** to discuss potential MVP revisions that have been identified, as feasible.

For more information about the MVP maintenance process, visit the MVP Maintenance webpage.

MIPS Value Pathways (MVPs) Proposals

Subgroups

MVP Proposals – Subgroups	
Definition	A subset of a group which contains at least one MIPS eligible clinician and is identified by a combination of the group Taxpayer Identification Number (TIN), the subgroup identifier, and each eligible clinician's National Provider Identifier (NPI).
Subgroup Eligibility	• Use the first segment of the MIPS determination period to determine the eligibility of clinicians intending to participate and register as a subgroup. • As previously finalized, each subgroup must include at least one MIPS eligible clinician.

Subgroup Registration	• Previously finalized that clinicians who choose to participate in a subgroup to report an MVP must register as a subgroup between April 1 and November 30 of the performance year. In addition to the required MVP registration information, the subgroup registration must include:
	  • A list of TIN/NPIs in the subgroup,
	  • A plain language name for the subgroup (which will be used for public reporting),
	• Proposing to add a 3rd required element:
	  • A description of the composition of the subgroup, which may be selected from a list or described in a narrative.
	• CMS is also proposing that a clinician would only be allowed to register for one subgroup per TIN.

MIPS Value Pathways (MVPs) Proposals

Subgroups

MVP Proposals – Subgroups (Continued)	

Subgroup Scoring	• For measures calculated through administrative claims, CMS would calculate and score these measures at the TIN level (of the affiliate group), not at the subgroup level:
	  • **Foundational Layer (MVP Agnostic):** For each selected population health measure in an MVP, subgroups would be assigned the affiliated group's score, if available.
	  • **Quality Performance Category:** For each selected outcome-based administrative claims measure in an MVP, subgroups would be assigned the affiliated group's score, if available.
	  • **Cost Performance Category:** Subgroups would be assigned the affiliated group's cost score, if available for the cost performance category in an MVP.

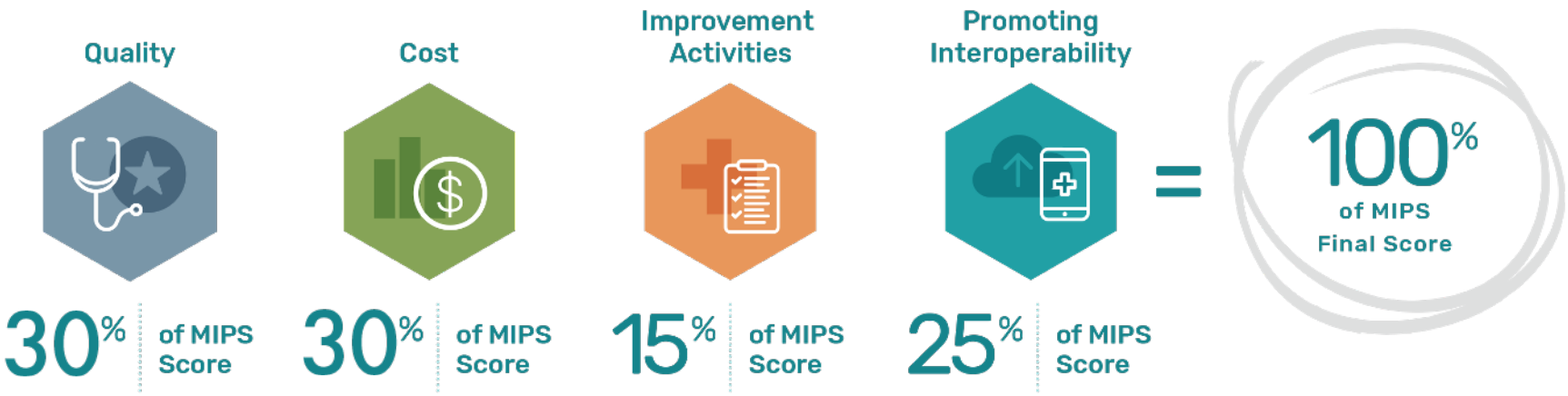
Subgroup Final Score	• Not assign a score for a subgroup that registers but doesn't submit data as a subgroup.

MIPS PROPOSALS

Merit-based Incentive Payment System (MIPS)

Quick Overview

MIPS 2023 Performance Categories



- Comprised of **4** performance categories.
- So what? The points from each performance category are added together to give you a MIPS final score.
- The MIPS final score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

2023 MIPS Proposals

Performance Category Weights

Performance Category	Performance Category Weights		
	2023 Traditional MIPS Individuals, Groups, Virtual Groups (no change for 2022)	2023 Traditional MIPS APM Entities (no change for 2022)	2023 APM Performance Pathway (APP) Individuals, Groups, APM Entities (no change for 2022)
 Quality	30%	55%	50%
 Cost	30%	0%	0%
 Improvement Activities	15%	15%	20%
 Promoting Interoperability	25%	30%	30%

CMS is statutorily required to weigh cost and quality equally beginning with the 2022 performance year.

Note: The APP has different scoring weights compared to APM Entities participating in traditional MIPS.

When an APM Entity reports traditional MIPS, CMS will reweight the quality performance category to 55% according to traditional MIPS performance category reweighting rules, as opposed to 50% under the APP.

MIPS PROPOSALS

Performance Categories

2023 MIPS Proposed Changes

Quality Performance Category

Basics:

- Proposals, changes, and removals of quality measures
- Revisions to benchmarks used for 2023 performance year scoring of administrative claims measures
- Updates to data completeness threshold
- Changes to the definition of a high priority measure
- Revisions to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS case-mix adjustment

Quality Measures

CMS proposes a total of **194** quality measures for the 2023 performance period:

- Addition of **9** quality measures, including 1 new administrative claims measure, 1 composite measure, 5 high priority measures, and 2 new patient-reported outcome measures.
- Substantive changes to **75** existing MIPS quality measures.
- Addition/removal of measures from specialty sets.
- Removal of **15** quality measures and partial removal of 2 quality measures (2 measures proposed for removal for traditional MIPS and proposed for retention for MVP use only).

QCDR measures are approved outside the rulemaking process and aren't included in this total.

2023 MIPS Proposed Changes

Quality Performance Category

Basics:

- Proposals, changes, and removals of quality measures
- Revisions to benchmarks used for 2023 performance year scoring of administrative claims measures
- Updates to data completeness threshold
- Changes to the definition of a high priority measure
- Revisions to the CAHPS for MIPS case-mix adjustment

Data Completeness

2022 Final	2023 Proposed
• To meet data completeness, performance data must be reported for at least **70%** of the denominator eligible encounters.	• Maintain data completeness threshold at **70%** for the 2023 performance year. • Increase the data completeness threshold to **75%** for 2024 and 2025.

Note: These proposals don't apply to CMS Web Interface measures; as a reminder, in the 2023 performance period, the CMS Web Interface is only available to Medicare Shared Savings Program Accountable Care Organizations (ACOs) reporting via the APM Performance Pathway (APP).

2023 MIPS Proposed Changes

Quality Performance Category

Basics:

- Proposals, changes, and removals of quality measures
- Revisions to benchmarks used for 2023 performance year scoring of administrative claims measures
- Updates to data completeness threshold
- Changes to the definition of a high priority measure
- Revisions to the CAHPS for MIPS case-mix adjustment

High Priority Measures

- A high priority measure is defined as an:
  - Outcome (including intermediate-outcome and patient-reported outcome) quality measure,
  - Appropriate use quality measure,
  - Patient safety quality measure,
  - Efficiency quality measure,
  - Patient experience quality measure,
  - Care coordination quality measure, or
  - Opioid-related quality measure.

- CMS proposes to expand the definition of a high priority measure to include **health equity-related quality measures**.

2023 MIPS Proposed Changes

Quality Performance Category

Basics:

- Proposals, changes, and removals of quality measures
- Revisions to benchmarks used for 2023 performance year scoring of administrative claims measures
- Updates to data completeness threshold
- Changes to the definition of a high priority measure
- Revisions to the CAHPS for MIPS case-mix adjustment

CAHPS for MIPS Survey

- The CAHPS for MIPS case-mix adjustment model includes the following case-mix adjustors:
  - Age
  - Education
  - Self-reported general health status
  - Self-reported mental health status
  - Proxy response
  - Medicaid dual eligibility
  - Eligibility for Medicare's low-income subsidy
  - Asian language survey completion (beginning 2022)
- CMS proposes to change the case-mix adjustor for "**Asian language survey completion**" to use the "**language other than English spoken at home**" variable instead.

2023 MIPS Proposed Changes

Improvement Activities Performance Category

Basics:

- Continue streamlining and strengthening improvement activities Inventory

Improvement Activities Inventory

- **Add 4** new improvement activities
  - Subcategories include: Achieving Health Equity, Expanded Practice Access, and Emergency Response and Preparedness.
- **Modify 5** existing improvement activities.
- **Remove 6** existing improvement activities
  - Subcategories include: Beneficiary Engagement, Population Management, and Patient Safety and Practice Assessment.

2023 MIPS Proposed Changes

Cost Performance Category

Basics:

- Establish maximum cost improvement score

Cost Improvement Scoring

- Starting with the 2022 performance period:
  - CMS is proposing to establish a **maximum cost improvement score** of **1** percentage point out of 100 percentage points available for the cost performance category.
  - CMS is proposing to establish this to adhere to the statutory requirement of accounting for improvement in the assessment of performance under the cost performance category.

2023 MIPS Proposed Changes

Promoting Interoperability Performance Category

Basics:

- Discontinue automatic reweighting policy for certain clinician types
- Modify measures and reporting requirements
- Adjust measure points

Reweighting

2022 Final	2023 Proposed
Automatic reweighting applies to following clinician types: • Nurse practitioners • Physician assistants • Certified registered nurse anesthetists • Clinical nurse specialists • Clinical social workers • Physical therapists • Occupational therapists • Qualified speech-language pathologist • Qualified audiologists • Clinical psychologists, and • Registered dieticians or nutrition professionals Automatic reweighting applies to MIPS eligible clinicians, groups and virtual groups with following special statuses: • Ambulatory Surgical Center (ASC)-based • Hospital-based • Non-patient facing • Small practices	**Discontinue** automatic reweighting for following clinician types beginning with 2023: • Nurse practitioners • Physician assistants • Certified registered nurse anesthetists • Clinical nurse specialists **Continue** automatic reweighting for following clinician types in 2023: • Clinical social workers • Physical therapists • Occupational therapists • Qualified speech-language pathologists • Qualified audiologists • Clinical psychologists, and • Registered dieticians or nutrition professionals

2023 MIPS Proposed Changes

Promoting Interoperability Performance Category

Basics:

- Discontinue automatic reweighting policy for certain clinician types
- Modify measures and reporting requirements
- Adjust measure points

Reweighting (continued)

2022 Final	2023 Proposed
When participating in MIPS at the APM Entity level (reporting either the APP or traditional MIPS), Promoting Interoperability data must be reported at the **individual or group level**.	When participating in MIPS at the **APM Entity level,** CMS would allow APM Entities to report Promoting Interoperability data at the APM Entity level. • APM Entities would still have the option to report this performance category at individual and group level.

2023 MIPS Proposed Changes

Promoting Interoperability Performance Category

Basics:

- Discontinue automatic reweighting policy for certain clinician types
- Modify measures and reporting requirements
- Adjust measure points

Public Health and Clinical Data Exchange Objective

2022 Final	2023 Proposed
There are 3 active engagement options for the measures within this objective: • **Option 1**: Completed Registration to Submit Data • **Option 2**: Testing and Validation • **Option 3**: Production	Modify the levels of active engagement for the Public Health and Clinical Data Exchange Objective measures: • **Combine Options 1 and 2** into a single option titled "Pre-production and Validation" and rename Option 3 to "Validated Data Production" for a total of 2 options. • **Require MIPS eligible clinicians to submit their level of active engagement** in addition to requiring a yes/no response for the required Public Health and Clinical Data Exchange measures. • **Limit time clinicians stay in Option 1 to 1 year**

2023 MIPS Proposed Changes

Promoting Interoperability Performance Category

Basics:

- Discontinue automatic reweighting policy for certain clinician types
- Modify measures and reporting requirements
- Adjust measure points

Query of Prescription Drug Monitoring Program (PDMP) Measure

2022 Final	2023 Proposed
This is an **optional** measure, worth 10 bonus points in the 2022 performance period.	Make the PDMP measure a **required** measure beginning with the 2023 performance period. • Add exclusions for the measure and make it worth 10 points. • Expand the scope of the measure to include not only Schedule II opioids but also Schedules III and IV drugs.

2023 MIPS Proposed Changes

Promoting Interoperability Performance Category

Basics:

- Discontinue automatic reweighting policy for certain clinician types
- Modify measures and reporting requirements
- Adjust measure points

Health Information Exchange (HIE) Objective

2022 Final	2023 Proposed

There are 2 options for satisfying the HIE objective.
• **Option 1**: Report both
  • Support Electronic Referral Loops by Sending Health Information, and;
  • Support Electronic Referral Loops by Receiving and Reconciling Health Information.
• **Option 2**: Health Information Exchange Bi-Directional Exchange
	Make a third option for satisfying the HIE objective, in addition to the 2 existing options.
	• **Option 3**: Participation in the Trusted Exchange Framework and Common Agreement (TEFCA).

MIPS PROPOSALS

Final Scoring

2023 MIPS Proposed Changes

Final Scoring Proposals

2023 Proposals for Facility-Based Measurement:

- Complex Patient Bonus: A facility-based MIPS eligible clinician would be eligible to receive the complex patient bonus, even if they don't submit data for at least one MIPS performance category.

- Virtual Groups: Permit facility-based measurement of a virtual group given it meets the specified eligibility standards of having 75% or more of the eligible clinicians in the virtual group meet the definition of a facility-based MIPS eligible clinician.
  - CMS would score eligible virtual groups under facility-based measurement even if no data were submitted; by electing to form a virtual group, virtual groups signal their intent to participate and be scored as a virtual group.

2023 MIPS Proposed Changes

Final Scoring Proposals

Performance Threshold 2022 Final

As required by statute, beginning with the 2022 performance year/2024 payment year, the performance threshold must be either the mean or median of the final scores for all MIPS eligible clinicians for a prior period.

- Use the **mean final score from the 2017 performance year/2019 payment year**:
  - Performance threshold: **75** points.
  - Additional performance threshold: **89** points for exceptional performance.

Performance Threshold 2023 Proposed

Continue using the mean final score from the 2017 performance year/2019 MIPS payment year:

- **Set the performance threshold at 75 points** for the 2023 performance year/2025 payment year.

The 2022 performance year/2024 payment year was the final year for an additional performance threshold/additional MIPS adjustment for exceptional performance.

2023 MIPS Proposed Changes

Performance Threshold and Payment Adjustments

2022 Final

Final Score 2022	Payment Adjustment 2024
≥89 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance—minimum of additional 0.5%
75.01-88.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
75 points	• Neutral payment adjustment
18.76-74.99 points	• Negative payment adjustment between -9% and 0%
0-18.75 points	• Negative payment adjustment of -9%

2023 Proposed

Final Score 2023	Payment Adjustment 2025
75.01-100 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
75 points	• Neutral payment adjustment
18.76-74.99 points	• Negative payment adjustment between -9% and 0%
0-18.75 points	• Negative payment adjustment of -9%

The 2022 performance year/2024 payment year was the final year for an additional performance threshold/additional MIPS adjustment for exceptional performance.

PUBLIC REPORTING PROPOSALS

2023 QPP Public Reporting Proposals

2023 Proposed

Utilization Data

- Publicly report procedures commonly performed on individual clinician profile pages to aid patients in finding clinicians who may appropriately serve their needs.
  - Adding utilization data to profile pages would allow patients to find clinicians who have performed specific types of procedures.

Telehealth Indicators

- Publicly report a telehealth indicator, as applicable and technically feasible, on individual clinician and group profile pages for those clinicians furnishing covered telehealth services.
  - Adding telehealth indicators to profile pages will help to empower patients' healthcare decisions.

ADVANCED APM PROPOSALS

2023 Advanced APMs Proposed Changes

- Request for Information on Quality Payment Program Incentives Beginning in Performance Year 2023; CMS is seeking input from a series of question addressing **the impact on eligible clinicians' participation in Advanced APM given the changes occurring in Advanced APM Incentive Payments.**
  - CMS notes that the statute does not provide for any financial incentives for eligible clinicians who achieve QP status in QP Performance Period 2023/payment year 2025.
  - An enhanced conversion factor will come into place in QP Performance Period 2024/payment year 2026.

- Request for Information: Potential Transition to Individual QP Determination Only; CMS is requesting public comment on the idea of transitioning away from an APM Entity level QP determination and instead calculating Threshold Scores and **making QP determinations at the individual eligible clinician level for all eligible clinicians in Advanced APMs and Other Payer Advanced APMs**

2023 Advanced APMs Proposed Changes

- Medical Home Model 50 Clinician Limit: CMS is proposing to **apply the 50 clinician limit to the APM Entity participating in the Medical Home Model.**
  - CMS would identify the clinicians in the APM Entity by using the TIN/NPIs on the participation list of the APM Entity on each of the 3 QP determination dates (March 31, June 30, and August 31).
  - This policy would become effective in the 2023 performance year.

- Nominal Risk Expiration: CMS proposes to remove the 2024 expiration of the 8% minimum on the Generally Applicable Nominal Risk standard for Advanced APMs and **make the 8% minimum permanent**.

MEDICARE SHARED SAVINGS PROGRAM PROPOSALS

Increasing Participation in Accountable Care Models in Underserved Communities (PFS NPRM)

- Advance Investment Payments
- Smoothing the Transition to Performance-Based Risk
- Increased Opportunities for Low Revenue ACOs to Share in Savings
- Proposal to Implement a Health Equity Adjustment

Increasing Participation in Accountable Care Models in Underserved Communities (PFS NPRM)

- *Advance Investment Payments*
- an opportunity for many providers in rural and other underserved areas to join together as ACOs, building the infrastructure needed to succeed in the program, and promote equity by holistically addressing patient needs, including social needs.
- eligible ACO may receive a one-time fixed payment of $250,000 and quarterly payments for the first two years of the 5-year agreement period. The advance investment payments would be recouped once the ACO begins to achieve shared savings in their current agreement period and in their next agreement period, if a balance persists.

Increasing Participation in Accountable Care Models in Underserved Communities (PFS NPRM)

- *Smoothing the Transition to Performance-Based Risk*
- Propose to allow ACOs inexperienced with performance-based risk to participate under a one-sided model for a total of 7 years before transitioning to two-sided risk
- Propose to allow ACOs currently participating in Level A or B the option to elect to continue in their current level of the BASIC track glide path for the remainder of their agreement
- Propose to remove the limitation on the number of agreement periods an ACO can participate in Level E of the BASIC track; participation in the ENHANCED track would be optional.
- Responsive to concerns that particularly smaller providers in rural and underserved settings need additional time to transition to two-sided risk, and that quickly forcing providers to adopt two-sided risk models was a barrier to participation in the Shared Savings Program.

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- *Increased Opportunities for Low Revenue ACOs to Share in Savings*
- Propose to enable certain low revenue ACOs participating in the BASIC track to share in savings even if the ACO does not meet the minimum savings rate (MSR) requirement.
- Proposed reduced or sliding scale approach for determining shared savings.
- The proposed approach would provide payments to ACOs with the greatest need for shared savings, in particular smaller, rural ACOs which tend to be less capitalized, allowing for investments in care redesign and quality improvement activities.
- Aligns with the other proposals to encourage participation by new ACOs and ACOs that focus on underserved populations, e.g. the advance investment payments

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- *Proposal to Implement a Health Equity Adjustment*
- Up to 10 bonus points to an ACO's MIPS quality performance category
- Use the area deprivation index (ADI) score and Medicare and Medicaid dually eligible status to assess underserved populations which would allow capturing of broader neighborhood level and individual beneficiary characteristics
- This health equity adjustment would not risk adjust away disparities (thereby masking them), and does not set lower quality standards for underserved populations— rather, this proposal would reward those providers who provide excellent care for underserved populations.
- Because the upside-only reward would only go to those providers who serve a minimum percentage of underserved populations, this means that there would also be greater incentive to care for underserved populations.

Comments WERE due September 6, 2022

When and Where to Submit Comments

- See proposed rule for information on submitting comments by close of 60-day comment period on **September 6, 2022** (when commenting **refer to file code CMS-1770-P**).

- Instructions for submitting comments can be found in proposed rule; FAX transmissions won't be accepted.

- You must officially submit your comments in one of following ways:
  - Electronically through Regulations.gov
  - By regular mail
  - By express or overnight mail
- For additional information, please go to the Quality Payment Program (QPP) website: qpp.cms.gov. The proposed rule can also be accessed through the "Regulatory Resources" section of the QPP Resource Library.

Resources

- **CMS Press Release – Medicare Physician Fee Schedule Proposed Rule**
- https://www.cms.gov/newsroom/press-releases/cms-proposes-physician-payment-rule-expand-access-high-quality-care

- **CMS Fact Sheet – Medicare Physician Fee Schedule Proposed Rule**
- https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-proposed-rule

- **CMS Fact Sheet – Medicare Shared Savings Program Proposed Changes**
- https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-proposed-rule-medicare-shared-savings-program

- **CMS Fact Sheet – Quality Payment Program Proposed Changes**
- https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1972/2023%20Quality%20Payment%20Program%20Proposed%20Rule%20Resources.zip

- **Unpublished PFS Proposed Rule**
- https://www.federalregister.gov/public-inspection/2022-14562/medicare-and-medicaid-programs-calendar-year-2023-payment-policies-under-the-physician-fee-schedule


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