COVERAGE OF THE FINAL 2023 MEDICARE PHYSICIAN FEE SCHEDULE AND QUALITY PAYMENT PROGRAM

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Reimbursement upheaval, telehealth coverage changes and a major shift to the facility-based E/M services are just several of the critical updates to Medicare policy contained in the final 2023 physician fee schedule. Understand the ins and outs of 2023-effective updates to ensure your coding, billing, compliance and quality reporting strategies are in shape to meet the challenges of the new year.

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PHYSICIAN PAYMENTS

Pay cuts looming, advocacy groups turn to lawmakers for reprieve

The final 2023 Medicare physician fee schedule that CMS released Nov. 1 confirmed a harsh reality: Medical groups will see a 4.5% cut to the conversion factor (CF) on Jan. 1, 2023, as the CF falls to a rate of $33.06 and sends some charges under the Part B payment system tumbling.

The $33.06 CF rate comes in $1.55 less than the CY 2022 rate of $34.61. The anesthesia CF also will drop 4.4% in 2023, taking a cut from the CY 2022 rate of $21.56 to $20.61 in CY 2023, a reduction of $0.95 year over year.

Not all specialties will bear the brunt of the CF reduction equally, as CMS' yearly effort at revising misvalued codes alters the contribution of relative value units (RVU) to the final payment picture. Final fees are a product of RVU inputs — practice expense, malpractice and work — multiplied by the CF.

Medical practices faced a similar situation only a year ago, when CMS finalized a 4% cut to the CF for CY 2022. However, lawmakers intervened to roll back the CF reduction, as well as planned sequester and PAYGO cuts.

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Advocacy groups are now urging members of Congress to again forestall the Part B payment decreases.

Within an hour of the rule's Nov. 1 release, the AMA issued a statement from President Jack Resneck Jr., M.D., stating that the "payment schedule released today puts Congress on notice that nearly 4.5 percent across-the-board reduction in payment rates is an ominous reality unless lawmakers act before Jan. 1."

The finalized pay cuts would sow "financial instability" within the Part B payment system and threaten access to care, Resneck said.

On Nov. 2, the American College of Physicians echoed those remarks. "Medicare payments to physicians have been held flat for years, amounting to a significant decrease when accounting for inflation and the rising cost of running a medical practice," said Ryan D. Mire, M.D., MACP, ACP president in a statement. "The significant payment cuts that are scheduled for next year must be prevented in order to ensure that medical practices are able to remain open and physicians are able to work with Medicare beneficiaries."

Is intervention still a possibility this year? "Due to the dire nature of these cuts combined with the potential effect of the 4% PAYGO sequestration, we feel confident that Congress will take steps to mitigate these cuts," says Claire Ernst, director of government affairs with the Medical Group Management Association (MGMA) in Washington, D.C. "That being said, we are not taking our foot off the gas in advocating on this issue until we see something passed into law — preferably before the end of the year."

Editor's note: *CMS posted a new +2.4% conversion factor for 2023 Medicare fees. On the heels of the omnibus spending bill that President Biden signed into law Dec. 29, CMS took up one of its imperatives to scale down the reduction in Medicare payments. The agency posted a revised conversion factor of $33.8872, replacing the $33.0607 amount originally released with the final 2023 Medicare physician fee schedule.*

The updated rate computes to a 2.1% drop in the CF amount between 2022 and 2023, well below the expected 4.5% decrease that was on the books had Congress not intervened. The 2.1% drop also is an improvement over the 2.5% cut that lawmakers touted and appears to lift reimbursement out of that hole by 2.4%.

Revaluing services in the PFS

In the final rule, CMS addressed a key component of pay rates—work RVUs—for more than 160 new, revised or potentially misvalued codes across a range of procedures and E/M services. For instance, the agency set work RVUs for a series of anterior hernia repair codes, **49591-49596** and **49613-49618**, as well as parastomal repair codes **49621-49622**. The work RVUs range from 5.96 for an initial repair less than 3 cm to 22.67 for a recurrent repair greater than 10 cm.

As the agency agreed to the new reporting format for other E/M services outside of the office setting, it revamped work RVUs across a range of services. The series of initial hospital and observation care (**99221-99223**), a new combined code category in 2023, will see a significant

reduction in work RVUs. For instance, code 99223, corresponding to a high level of medical decision-making or 75 minutes of time, has its work RVUs chopped by 9%.

However, subsequent inpatient or observation care services (**99231-99233**) will get a big raise. Work RVUs increase by 31% for 99231; 14% for 99232; and 20% for 99233.

In the final rule, CMS notes that the AMA's RVS Update Committee (RUC) "reviewed and resurveyed" inpatient and observation care services for its January 2022 meeting, offering revised work RVUs, as well as intraservice times and total times. The agency reports that several commenters disagreed with the proposed values for initial hospital and observation care services. However, "given the reductions for total times for these codes," the agency agreed to the RUC recommendations across the board, according to the final rule.

The work RVU inputs for other non-office E/M service are up and down. Except for lowest-level emergency department code **99281**, which will see its work RVUs nearly cut in half, the remainder of the ED series remains flat. Three out of seven nursing facility codes (**99304-99310**) will see a reduction in work RVUs. And five out of eight home visit codes (**99341-99345, 99347-99350**) are on track for reduced work RVUs as well.

See "Table 16: CY 2023 Work RVUs for New, Revised and Potentially Misvalued Codes" for the complete list of work RVU inputs for 2023.

CODING

CMS poised to accept most 2023 E/M revisions, with a few asterisks

As practices adjust to the AMA's updated E/M guidelines for visits in facilities and residential settings, Medicare won't present you with many unpleasant surprises.

CMS confirmed in the final rule that it will adopt the framework of the revised guidelines, including payment based on medical decision-making (MDM) or time. The agency will diverge from the AMA on some points, however.

Medicare will continue to not recognize subspecialties for the purposes of defining an initial vs. subsequent service. The AMA states that an initial service may be reported when the patient has not received any professional services during a facility stay from the physician or other qualified health care professional or another such practitioner of the exact same specialty and subspecialty who belongs to the same group practice. CMS does not recognize subspecialties, so the agency would not allow different subspecialists to report separate initial visits.

For non-physician practitioners (NPP), the agency finalized its proposal to have them remain their own specialties. "When advanced practice nurses and physician assistants are working with physicians, they are always classified in a different specialty than the physician," CMS noted.

That is another divergence from the AMA's 2023 E/M guidelines, which state that "when advance practice nurses and physician assistants are working with physicians, they are considered as working in the same specialty and subspecialty as the physician."

But for Medicare, the NPP policy is nothing new, explains Betsy Nicoletti, CPC, of North Andover, Mass.-based Medical Practice Consulting. "This is CMS affirming their longstanding policy," she says. Unlike private insurers, Medicare doesn't enroll NPPs to a medical or surgical specialty, she adds, so the concept of NPPs being focused on a given physician specialty doesn't apply.

On one key point, you'll find CMS and the AMA in alignment: if a patient transitions from observation to inpatient status, it does not constitute a new stay in the facility. The policy applies to both observation/inpatient and nursing facility codes. For example, when a patient is admitted to observation status and the clinician subsequently decides to admit the patient to inpatient status, it is still the same stay for the purpose of billing an initial or subsequent visit.

Observation/inpatient-specific policies

8-to-24-hour rule remains in place. CMS finalized its plan to continue to apply the 8-to-24-hour rule for the newly consolidated inpatient or observation and discharge codes to deter what the agency views as the potential for duplicative payments. That means that:

- For stays of less than eight hours, report initial hospital or observation services (**99221-99223**).
- When the hospital admission is at least eight but less than 24 hours, report same day admission and discharge from hospital (**99234-99236**).
- When a patient is admitted for more than 24 hours you should report an initial hospital/observation code for the date of admission (99221-99223) and hospital discharge day management code (**99328-99239**).

Medicare: Same-day admission at a different site not separately payable. When a patient is admitted to observation or inpatient status during a visit provided the same day in a different place of service (e.g., office, hospital ED or nursing facility), Medicare will continue to consider that visit bundled as part of the initial hospital inpatient or observation care service, CMS stated. The AMA in its 2023 E/M guidelines added a new provision that would allow separate billing (with modifier 25) for a visit in a different setting when the decision to admit the patient was made during that visit. For Medicare, at least, that service will continue to be bundled as part of the initial observation/inpatient visit.

Medicare will continue its swing-bed policy. CMS will keep the policy that: "If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes apply." When the hospital bills the inpatient care as nursing facility care, then nursing facility E/M codes apply.

POS code has increased importance. Practices will need to carefully track place of service (POS) for codes 99221-99333, Nicoletti notes. "Even though we're using the same CPT codes [for observation and inpatient visits], we still need to use the right place of service to get our claims paid."

Observation would be considered outpatient place of service, so POS codes 19 (Off-campus outpatient hospital) or 22 (On-campus outpatient hospital) would apply, she says.

Report POS code 21 for inpatient status.

Nursing facility notes

Clinicians should continue to report Medicare's federally mandated initial nursing facility (NF) comprehensive assessment visits with initial NF visit codes **99304-99306**, CMS states in the final rule. But the agency also will allow practitioners to report either an initial or subsequent NF visit code (**99307-99310**) as appropriate, even if the service is furnished prior to the initial comprehensive assessment.

That flexibility means "a practitioner can see a patient in the nursing facility before the admitting physician completes the initial assessment," explains coding consultant Nancy Enos,

FACMPE, CPC-I, CPMA, CEMC, CPC emeritus, of Enos Medical Coding in Ft. Myers, Fla.

For example, "the NPP or another M.D. sees the patient to follow up on pneumonia that was treated in the hospital," Enos says. "The admitting physician hasn't been in to do the 'initial assessment.'" CMS is saying those other practitioners can use the initial or subsequent codes as appropriate to the service regardless of what the admitting physician is doing, she adds.

Also finalized: Medicare's existing policies that state that same-day office and emergency department visits would not be paid separately with a comprehensive nursing facility assessment. CMS considers them to be "duplicative," the agency states. Initial nursing facility care codes 99304-99306 include other services provided by the same practitioner on the same date at a different site, CMS reminds. And emergency department visits provided the same day as a comprehensive nursing facility assessment are not separately paid, even if different practitioners provide the services.

CMS bids grudging goodbye to 99318

While formally, CMS proposed to accept the AMA's planned deletion of annual nursing facility assessment visit code **99318** starting next year, the agency also sought comments on whether to keep the code in use for Medicare purposes. The agency worries that if other subsequent NF codes (99307-99310) are used instead, it "could cause an unwarranted increase in valuation of other services under the PFS, and CMS would not have a means of tracking how often these visits are occurring."

Code 99318 has a work RVU of 1.71 in 2022. Both CMS and the RUC believe that starting in January the bulk of these visits (85%) will be billed as 99309, which next year would have a work RVU of 1.92, as proposed by the RUC and accepted by CMS.

All the comments CMS received about 99318 supported the deletion of code 99318 and the use of other NF codes to report the Medicare-required service. The agency then finalized a decision not to reinstate the code and said it would instead accept subsequent NF visit codes for the service.

Medicare OK with merged residential codes

CMS finalized its acceptance of the AMA's changes to the home visit codes, which include deletion of codes for visits to domiciliary, rest home, custodial care services (**99324-99328** and **99334-99337**) and the merging of these services into the revised home or residence services codes (**99341-99342**, **99344-99345** and **99347-99350**), as well as code-level selection based on time or MDM.

CODING

CMS creates 3 new prolonged codes, won't assign frequency limits

Practices that report E/M services based on time could have to juggle up to six prolonged service codes in 2023 depending on where providers treat patients and on individual payer policy. CMS finalized three new prolonged service codes that will be reported based on the setting for the primary service—**G0316, G0317 and G0318**—and issued additional policies for prolonged service codes.

The HCPCS code descriptors for the new codes resemble the

> "We create Medicare-specific coding only when there is a significant program integrity concern or programmatic need, such as tailoring a code to a specific Medicare statutory benefit category."
>
> —CMS

descriptors for the CPT codes they replace. The codes require a full 15 minutes of additional time. They can only be used in conjunction with the highest code level in a code family, such as a subsequent hospital inpatient or observation visit (**99233**) or an initial nursing facility visit (**99306**). And the primary E/M visit must be coded based on time, which is calculated based on the performance of one or more of the nine activities in the CPT E/M guidelines.

However, take a close look at the HCPCS descriptors, because they also specify the primary codes they should be reported with:

- G0316 (Prolonged hospital inpatient or observation care evaluation and management service[s] beyond the total time for the primary service [when the primary service has been selected using time on the date of the primary service]; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact [list separately in addition to CPT codes **99223**, **99233**, and **99236** for hospital inpatient or observation care evaluation and management services]. [Do not report G0316 on the same date of service as other prolonged services for evaluation and management **99358**, **99359**, 99415, 99416, 99418]. [Do not report G0316 for any time unit less than 15 minutes]).
- G0317 (Prolonged nursing facility evaluation and management service[s] beyond the total time for the primary service [when the primary service has been selected using time on the date of the primary service]; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact [list separately in addition to CPT codes **99306**, **99310** for nursing facility evaluation and management services]. [Do not report G0317 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418]. [Do not report G0317 for any time unit less than 15 minutes]).
- G0318 (Prolonged home or residence evaluation and management service[s] beyond the total time for the primary service [when the primary service has been selected using time on the date of the primary service]; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact [list separately in addition to CPT codes **99345**, **99350** for home or residence evaluation and management services]. [Do not report G0318 on the same date of service as other prolonged services for evaluation and management 99358, 99359, **99417**]. [Do not report G0318 for any time unit less than 15 minutes]).

Descriptor language that lists excluded prolonged service codes comes from a parenthetical note for codes 99417 and 99418 in the 2023 CPT manual.

Practices can expect to receive approximately $31 for each unit of G0316 and G0317 and around $30 for G0318. The amounts are in line with the $31.40 that practices will receive for prolonged office/other outpatient code **G2212**.

At odds with the AMA, CMS makes its own time

CMS stood firm on its objections to CPT add-on codes for prolonged services on the same date as the face-to-face encounter (99417-99418). According to the final rule, CMS "disagreed with the CPT instructions regarding the point in time at which the prolonged code should apply" because it believes CPT guidelines create duplicative coding. The agency also noted that "we create Medicare-specific coding only when there is a significant program integrity concern or programmatic need, such as tailoring a code to a specific Medicare statutory benefit category."

Coders can't use the codes' descriptors to calculate prolonged services for hospital, nursing facility, home/residence or cognitive assessment services. CMS used the primary code's total time in the physician work time file—which is used to calculate payment—rounded to the nearest five-minute interval as the basis for its prolonged service codes. (*See the chart below* which contains the threshold times for one unit of a prolonged service codes and more details about this new policy.)

The rule increases the amount of time—and potentially revenue—a physician or qualified health care professional (QHP) can add to an E/M service. But that also means you will need to document that additional time. It will fall to coders to add up the minutes.

"Now you absolutely have to have a coder look at every prolonged services code," says Betsy Nicoletti, CPC, president of North Andover, Mass.-based Medical Practice Consulting. "Physicians can't do their own coding if they are billing based on time."

Editor's note: *On March 14, 2023, CMS announced an update that cuts 15 minutes from the originally published threshold times for* ***G0316*** *(Prolonged inpatient or observation services by physician or other QHP). The correction, officially made to the final 2023 Medicare physician fee schedule, lowers the threshold for inpatient hospital visit code 99223 with G0316 from 105 minutes to 90 minutes; for subsequent hospital visit code 99233 with G0316 from 80 minutes to 65 minutes; and for same-day admit/discharge code 99236 with G0316 from 125 minutes to 110 minutes.*

CMS delivers 4 more surprises

Providers will have wider coding and reimbursement options thanks to three more changes that CMS confirmed in the final rule:

1. "Prolonged service time can be reported when furnished on any date within the primary visit's surveyed timeframe," CMS writes in the final rule. Survey time is data that the AMA's RVS Update Committee (RUC) collects and uses to value codes. For example, the survey time for nursing facility services (**99304-99310**) "included the day before, the day of, and up to and including 3 days post the date of service,"

> **"Prolonged service time can be reported when furnished on any date within the primary visit's surveyed time frame."**
>
> —CMS

CMS writes in the final rule. However, the survey time for a same day admission and discharge visit (**99324-99326**) is the date of the encounter.

2. No frequency limits for prolonged services. You will not see medically unlikely edits (MUE) for the new G codes, according to several statements in the final rule. For example, "É there would not be any frequency limitation; therefore, we proposed that physicians and NPPs would be able to bill G0317 for each additional 15-minute increment of time beyond the total time for CPT codes 99306 and 99310."
3. In a change from the proposed rule, CMS will allow practices to report prolonged service time with cognitive assessment code **99483**.
4. The new prolonged service codes will be added to the list of telehealth services on a permanent basis.

Resources

- Final 2023 Medicare physician fee schedule (display version): *https://public-inspection.federalregister.gov/2022-23873.pdf*
- CY 2023 PFS Final Rule Physician Work Time (Zip file): *www.cms.gov/files/zip/cy-2023-pfs-final-rule-physician-work-time.zip*

CODING

Prolonged service threshold chart

Share this prolonged service code chart with coders to ensure accurate claims. The first column lists the primary E/M code, followed by the add-on HCPCS code that pairs with the primary code. The threshold column contains the minimum time required to report one unit of the add-on code.

The time period column gives the date or range of days for counting time for the visit. For example, "3 + date of visit + 7" indicates the coder can count time for work performed up to three days before the face-to-face encounter, the date of the face-to-face encounter and seven days after the encounter. However, the provider must document their time.

Primary	Code	Threshold	Time period
New office/outpatient (99205)	G2212	89	Date of visit
Established office/outpatient (99215)	G2212	69	Date of visit
Cognitive assessment (99483)	G2212	100	3 + date of visit + 7
Initial hospital (99223)	G0316	90	Date of visit
Subsequent hospital (99233)	G0316	65	Date of visit
Admit & discharge (99236)	G0316	110	Date of visit + 3
Initial nursing facility (99306)	G0317	95	1 + date of visit +3
Subsequent nursing facility (99310)	G0317	85	1 + date of visit +3
New home (99345)	G0318	140	3 + date of visit + 7
Established home (99350)	G0318	110	3 + date of visit + 7

Source: Table 24: Required time thresholds to report other E/M prolonged services

BILLING

CMS extends its split/shared exception for facility-based visits

Practices have another year to determine whether a physician or qualified health care professional bills a level-based split/shared visits based on performance of a key component of the encounter—history, physical exam or medical decision-making (MDM).

The delay should come as a relief to commenters who objected when CMS announced in the 2022 proposed rule that practices would have to use time to determine who performed the substantive portion of a visit. Under the proposal, the policy would have been effective Jan. 1, 2022. In the 2022 final rule CMS pushed the effective date to Jan. 1, 2023, to give practices time to adjust. You can strike that date from your calendar, however. The 2023 final rule sets the new effective date as Jan. 1, 2024.

Retention of key components confused commenters

When a practice uses the three key components, the service should be billed by the provider who performs at least one of the key components for a visit. However, under the 2023 update to the rest of the level-based code set, the history and physical exam will not be used to select the code. Several commenters asked about this discrepancy. According to CMS, when the visit includes a medically appropriate history and/or physical exam, a practice could count the performance of one or both service elements.

New definitions could be in the works

CMS split/shared policy is based on, but not identical to, the CPT guidelines for split/shared encounters. For example, CPT guidelines restrict split/shared coding to E/M visits based on time

and do not dictate who bills the service. CMS does not allow split/shared billing for office visits. However, a future version of the guideline could be more aligned with CMS policy.

"The AMA indicated in its public comment letter that it intended to refer the definition of split (or shared) services back to CPT for potential further review," CMS writes in the final rule. CMS will review the changes and take them into consideration for possible future rulemaking.

Practices that use split/shared coding and split/shared billing should be certain that staff members understand the difference between the two types of split/shared.

QUALITY PAYMENT PROGRAM

QPP changes arrive, as later reporting, payment hassles loom

Take stock of a series of annual updates to the Quality Payment Program (QPP) and Merit-based Incentive Payment System (MIPS) to succeed in 2023, but watch carefully as CMS prepares for a whole new MIPS paradigm and, for alternative payment model (APM) participants, a possible year without bonuses down the road.

The 2023 numbers are no surprise: As proposed, the MIPS category weights will be 30% for Quality, 30% for Cost, 15% for Improvement Activities and 25% for Promoting Interoperability. The data completeness threshold rises from 70% to 75%, and the performance threshold remains 75 points. CMS finalized all its earlier proposed weights.

The most MIPS reporters can be penalized for missing these targets is 9% of payments, while the amount of the positive adjustment for meeting the reporting targets will be based on how many positive reporters are in the program — given the near-100% positive reporting rate in the program, positive adjustments are likely to be a very small amount. As for the additional positive payment adjustment for "exceptional performance," that is phased out starting in 2023.

A deeper look at the measures

Nine of the proposed new Quality measures were finalized, including "Improvement in Patient-Reported Itch Severity" for psoriasis and dermatitis patients; "Screening for Social Drivers of Health"; and "Adult Immunization Status." The agency cut 11 measures, including "Biopsy Follow-Up" and "Leg Pain After Lumbar Fusion," making the final tally 198 measures, down from 200.

In 2023, the Cost category score will be calculated by CMS based on achievement and a year-to-year improvement in the "Total Per Capita Cost (TPCC)" and "Medicare Spending Per Beneficiary (MSPB) Clinician" measures. (Previously, CMS notes, all participants received a score of zero "because we didn't calculate cost measure scores for the 2021 performance period" to base improvement on.) The maximum improvement score will be 1 percentage point out of 100 percentage points available.

To derive the final Cost score, CMS will "subtract the number of cost measures with a significant decline from the number of cost measures with a significant improvement, then divide the result by the number of cost measures for which the MIPS eligible clinician or group was scored for 2 consecutive performance periods, and then multiply the result by the maximum improvement score."

You will find four Improvement Activities added for 2023, including "Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients."

You'll see several tweaks to the Promoting Interoperability category. For example, the "Query of Prescription Drug Monitoring Program (PDMP)" measure, made optional in 2021, is now mandatory unless an exclusion on other grounds can be claimed. Of the three active engagement options for measures within the Public Health and Clinical Data Exchange Objective, the first two, "Completed Registration to Submit Data" and "Testing and Validation," are combined

as "Pre-production and Validation"; the third, "Production," becomes "Validated Data Production."

APM Entities reporting MIPS will be able to report Promoting Interoperability data at the entity level if they wish, while nurse practitioners, physician assistants, certified registered nurse anesthetists and clinical nurse specialists, previous exempted from reporting this category, will now be required to do so unless exempt for other reasons.

Bonuses remain uncertain

There are some technical changes to the Advanced APM alternative to MIPS—for example, the 8% Generally Applicable Nominal Risk standard for participants, through which eligible clinicians can become eligible for Qualifying APM Participant (QP) status, had been slated to expire but has instead been made permanent. But QPs will probably be more concerned with a potentially painful development scheduled for 2025.

Under the terms of MACRA, Advanced APMs that meet performance targets are supposed to get an annual 5% lump sum bonus, which in payment year 2026 will switch to a 0.75% increase in their Medicare Part B payments. Depending on how it's implemented, that change will probably mean a haircut for many APMs — but, more immediately, as 2024 is the last lump-sum payment year authorized by MACRA, and the law makes no provision for 2025, Advanced APMs will get no bonus at all in 2025.

Jamie Miller, senior director, government relations with the American Medical Group Association (AMGA), says that's not good for current Medicare Shared Savings ACOs or prospective ones. "We're hearing from our members who are currently in or thinking about joining the Advanced APM program that if the 5% bonus is gone that will impact their decision whether or not to stay in, or to go into value-based care in the first place," he says.

While Congress — which must make the fix — is notoriously slow to act, there are signs of a planned rescue. Suzanne M. Joy, senior public affairs advisor for Holland & Knight LLP in Washington, D.C., perceives "an appetite for larger APM/MACRA fixes" in Congress, and "there's a solid chance of APM bonus extension happening; it's at the top of wish lists for a lot of major health care orgs."

Joy also expects that there'll be conversations on Capitol Hill about "more overarching MACRA and fee schedule fixes — including lack of inflation-based updates and a budget neutrality requirement."

Mara McDermott, vice president of McDermott+Consulting and executive director of the Value-Based Care Coalition in Washington, D.C., notes that 44 members of Congress from both parties sent Speaker of the

House Nancy Pelosi (D-Calif.) and Minority Leader Kevin McCarthy (R-Calif.) an open letter on Nov. 2 asking that the House pass by year's end the Value in Health Care Act (H.R. 4587) that would extend the 5% lump sum by five years.

MVPs on the way

MIPS reporters, meanwhile, might have their eyes on the progress of the MIPS Value Pathways (MVP) model that is intended to supplant the current system. Since its announcement in 2019, CMS has fiddled with MVP, which has fewer and broader reporting measures than the current model and in 2023 it will be available as a voluntary reporting method.

The program acquires five new MVPs, as the pathways that participants can choose are called: "Advancing Cancer Care," "Optimal Care for Kidney Health," "Optimal Care for Patients with Episodic Neurological Conditions,"

"Supportive Care for Neurodegenerative Conditions," and "Promoting Wellness."

These join the seven existing MVPs: "Advancing Care for Heart Disease," "Optimizing Chronic Disease Management," "Advancing Rheumatology Patient Care," "Improving Care for Lower Extremity Joint Repair," "Adopting Best Practices and Promoting Patient Safety within Emergency Medicine," "Patient Safety and Support of Positive Experiences with Anesthesia," and "Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes."

As in the current paradigm there are also Quality, Cost, Promoting Interoperability and Improvement Activity measures on which participants in each MVP will be scored, as well as Population Health measures. Participants may report as practice entities; due to the specialty-specific nature of many MVPs, providers in multispecialty practices are allowed to create subgroups for reporting purposes.

Dave Halpert, chief, client team of Roji Health Intelligence, a consultancy and data registry in Chicago, expects some double-dippers among the voluntary reporters. "Since CMS will use the score most favorable to the clinician, groups — and subgroups — will give MVP reporting a test run, but will concurrently remain in traditional MIPS," Halpert says. "We have several clients who are planning to utilize this approach, as it enables them to gain subgroup reporting experience without risking their ongoing MIPS performance."

Lauren Patrick, president and CEO of qualified registry Healthmonix in Malvern, Pa., says that "if a group or subgroup is aligned well with one of the MVPs, those groups will want to report that MVP. In fact, they could achieve a higher score reporting the four relevant Quality measures within the MVP than if they report six measures for traditional group or individual MIPS reporting. So there is interest, from the perspective of only needing to report and improve the most relevant measures for a group."

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>
> —Dave Halpert, chief, client team of Roji Health Intelligence Chicago, Illinois

Resource

- Letter to House leadership on MACRA reform, Nov. 2, 2022: *www.naacos.com/assets/docs/pdf/ 2022/Sign-OnLetterHouseLeadersreAPMBonus.pdf*

SHARED SAVINGS PROGRAM

Shared Savings offers rewards for ACOs in underserved areas, but others can benefit

By finalizing most of its proposed changes to the Medicare Shared Savings Program (MSSP), CMS is giving massive breaks to new and low-revenue accountable care organizations (ACO) that serve underserved communities, as well as enticements for others to stay. The agency evidently wants to bulk up enrollment, and some experts think it's worth a try.

The new deal for new entrants who meet targets associated with CMS' "health equity" goal of better care for such beneficiaries can be generous, including a one-time upfront payment of, potentially, hundreds of thousands of dollars, as well as quarterly bonuses over a two-year term.

MSSP is the mother ship for Medicare-sponsored ACOs. Its mix of no-risk, low-risk and high-risk tracks, titrating the amount of bonus earnings such organizations can gain by saving CMS money on care of beneficiaries as well as the money

they can conceivably lose if they fail to deliver such savings, has by both measures been a success since its inception in 2012.

According to an April 2022 CMS accounting, the program has "483 ACOs with over 525,000 participating clinicians serving more than 11 million Medicare beneficiaries." And it is delivering savings; a recent CMS report found it had spent $1.7 billion less in 2021 than the agency calculates it would have spent otherwise, making it "the fifth consecutive year the program has generated overall savings and high-quality performance results."

For a while CMS was pushing for MSSP ACOs to take on more risk, as seen in its Trump-era Pathways to Success program. But then the program began to exhibit issues with recruitment and retention; other programs appeared to be drawing prospective entrants away, and many new entrants had trouble adjusting to even the most modest requirements of the program.

How the payments work

The biggest boost comes from Advanced Incentive Payments (AIP) that will go to "low revenue ACOs that are inexperienced with performance-based risk É new to the Shared Savings Program É and that serve underserved populations." Such ACOs will be eligible for a "one-time fixed payment of $250,000 and per beneficiary quarterly payments for the first 2 years of an ACO's 5-year agreement period," the final rule states.

To be considered for the upfront payments, ACOs need to submit a supplemental application and proposed spend plan; possible quarterly payments will be based on the ACO's beneficiaries' status under Medicare Part D low-income subsidy (LIS) metrics and/or Medicare and Medicaid dual eligibility, or "the ADI national percentile rank of the census block group" where beneficiaries live.

"CMS is determined to get all traditional Medicare patients into an accountable care relationship by 2030," says Dave Halpert, chief, client team of Roji Health Intelligence, a consultancy and data registry in Chicago. "But the number of ACO participants has plateaued, and the number of patients in underserved communities is proportionately smaller than the nation at large."

Hence, the payments. "These will be critical, as startup costs are frequently cited as a significant barrier to entry in the ACO market," Halpert says. "By tying the magnitude of these payments to the number of patients who are dually eligible or reside in a high deprivation area, these AIPs will increase ACO participation, the number of beneficiaries cared for in ACOs and, specifically, to encourage ACO development in communities that are underrepresented in the existing ACO world."

Even if they don't qualify for the upfront bonuses, new entrants with no prior shared-savings experience could be eligible to stay in a one-sided shared savings model for five years, rather than being pushed into double-sided risk after a few years as is currently the case. That would allow new entrants "more time to invest in infrastructure and redesigned care processes for high quality and efficient health care service delivery."

John Torontow, M.D., MPH, executive vice president and national medical director of Vytalize Health, a consultancy to ACOs in Hoboken, N.J., thinks the changes will significantly lower barriers to entry. "By giving ACOs more time to advance to greater risk, CMS will encourage more independent physicians to join the program," he says, "Making health equity a specific goal of the Shared Savings Program and then backing it up by bolstering ACOs that provide high-quality care to underserved patients will allow for more Medicare patients to take advantage of the care coordination that is the promise of advanced primary care."

Gary Thompson, Vytalize's chief business officer, predicts similar benefits from the added assistance to ACOs that treat beneficiaries with multiple chronic conditions in underserved areas or populations with a high concentration of dual-eligibles.

These ACOs get one more major perk: they're eligible for a "health

equity adjustment" that adds as much as 10 points to their quality performance score if they report all-payer electronic clinical quality measures (eCQMS)/MIPS CQMs, are high-performing on quality, and serve a high proportion of underserved beneficiaries. The adjustments go up based on the volume of beneficiaries from underserved communities the ACO serves.

For the rest

There are some breaks as well for MSSP ACOs who may not qualify for these extraordinary perks.

For example, for MSSP ACOs that are taking on risk, the "sliding scale" that was in effect before 2021 for determining whether ACOs met the performance requirements for recouping savings these ACOs is coming back.

CMS expressed its "concerns that the current structure of the quality performance standard creates a cliff of 'all-or-nothing' scoring where an ACO may be ineligible to share in savings due to a minor difference between its MIPS Quality performance category score and the quality performance standard required to share in savings at the maximum sharing rate for the applicable performance year," according to the final rule.

An ACO that does not meet the quality performance standard but is reporting at least three eCQMs or MIPS CQMs can have its savings share calculated by multiplying a figure derived from its MIPS Quality performance category score based on those CQMs, two claims-based measures calculated by CMS, and its CAHPS for MIPS survey score, by the (regular) sharing rate for the ACO's track.

It bears remembering as well that, insofar as they pick up beneficiaries from underserved communities, older ACOs can get in on some of the largesse laid out for new ACOs. For example, they are eligible for the aforementioned health equity adjustment to their performance score if they report three eCQMs/MIPS CQMs and the CAHPS for MIPS survey and have beneficiaries from underserved groups.

New CQMs loom

The eCQMs/MIPS CQMs proposed reporting method will not become mandatory for Shared Savings ACOs until 2025. Ambitious ACOs that choose to do so voluntarily now get a scoring break: They only need to achieve a 30th percentile benchmark on one eCQM/MIPS CQM measure, rather than in all the benchmarked measures reportable under CMS Web Interface, the popular reporting method that eCQMs/MIPS CQMs will replace.

Both are technically electronic CQMs; the "short version" of the difference between them, Halpert says, is that one is reported by registries rather than directly by the provider. "They're calculated slightly differently," he says. "But CMS is looking at the same type of information from one version to the next. The MIPS CQMs offer qualified registries a bit more latitude in how we can obtain the required information on the numerators — and that can be very useful to ACOs when information is documented inconsistently between their practices and providers."

The deadline hangs over many ACOs that have wanted to avoid offloading the job to a registry.

As recently as 2021, only 12 ACOs opted for the voluntary eCQMs/MIPS CQMs reporting, Halpert says. "In order to report on all patients, ACOs with disparate data sources need to be able to track a unique patient across the continuum of care. Unless an ACO has the ability to aggregate data or partners with a Clinical Data Registry that can do so, they will be unable to produce valid numerators and denominators."

In the final rule, CMS has tinkered with the requirement to make it less onerous, but still, Halpert says, "those offerings do not get to the heart of the issue, which is that many ACOs are not ready for what will be a mandatory reporting requirement in 2025."

For the time being, these ACOs will have to console themselves that the end of the CMS Web Interface method, an unpopular side effect of the switchover, has

been pushed forward again to 2024, when the new electronic reporting methods are made mandatory.

More changes finalized

All of the significant technical adjustments floated in the proposed rule were finalized, including:

- Addition of chronic pain management and prolonged services G-codes to the mix of codes that will determine beneficiary assignment in 2023.
- An adjustment of the times at which CMS will obtain CMS Certification Numbers (CCN) for providers and suppliers from PECOS for assignment purpose.
- Alteration of the MSSP performance benchmarking methodology "to reduce the effect of ACO performance on ACO historical benchmarks, increase opportunities for ACOs caring for medically complex, high-cost beneficiaries, and strengthen incentives for ACOs to enter and remain in the Shared Savings Program," per the rule. The main instrument of this would be the addition of an Accountable Care Prospective Trend (ACPT) factor to the formula.

Thompson says this should be a plus for many ACOs because it will "account for the effect of ACOs on overall health care trends as well as modifying individual ACO benchmarks upon renewal to adjust their new benchmark," and thus "'add back' a portion of the savings that [ACOs] created will help keep more ACOs in the game."

The American Medical Group Association (AMGA), however, and other commenters to the proposed rule expressed concern that the new method might not work as expected. AMGA recommended that CMS "calculate the updated benchmark with the new method and under the current national-regional blend as finalized in the Pathways to Success rule. The ACO would then select the updated benchmark of its choosing." But that recommendation was rejected.

"Uncertainty in the program just makes it that much more difficult for providers to know what they're signing up for when they agree to participate in this," says Darryl Drevna, AMGA's senior director of regulatory affairs.

Resource

- CMS press release, "Medicare Shared Savings Program Saves Medicare More Than $1.6 Billion in 2021 and Continues to Deliver High-quality Care," Aug. 30, 2022: *www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-16-billion-2021-and-continues-deliver-high*

PHYSICIAN FEE SCHEDULE

Fee schedule round-up: More policy updates coming your way

Don't miss out on additional regulatory changes contained in the final 2023 Medicare physician fee schedule, from global period E/M visits to supply cost revisions and more. For example:

- **CMS again broaches, but doesn't take action on, global surgical bundles.** The agency yet again addressed the valuation of global surgical packages, affirming its stance that reform is necessary. "We continue to believe that (1) there is strong evidence suggesting that the

current RVUs for global packages are inaccurate; (2) many interested parties agree that the current values for global packages should be reconsidered, whether they believe the values are too low or too high; and (3) it is necessary to take action to improve the valuation of the services currently valued and paid under the PFS as global surgical packages," CMS states in the final rule. The agency says that it wants to "re-engage with the public" about global packages and "welcome[s] additional insights from interested parties as we consider appropriate next steps." Stay tuned for more, and weigh in with relevant commentary.

Most specialties projected to lose charges in 2023: Fee schedule

The number of specialties welcoming a boost to their allowed charges in 2023 is far outpaced by those facing projected cuts, according to relative value unit (RVU) revisions announced in the final 2023 Medicare physician fee schedule released Nov. 1.

A total of 11 specialties, led by diagnostic testing facility at +7% and infectious disease at +4%, are on track for an increase in charges based on the combined impact of work, practice expense and malpractice RVUs, according to an analysis of Table 148 in the final rule. In contrast, 36 specialties will face expected reductions to allowed charges due to slashed RVUs in at least one of the three categories.

The charts below reveal the 11 specialties in the black, along with a comparative look at 11 of the 36 specialties that are at least -2% in the red. Another 21 specialties face a -1% cut, while eight specialties are flat year-to-year.

"The most widespread specialty impacts of the RVU changes are generally related to the changes to RVUs for specific services resulting from the misvalued code initiative, including RVUs for new and revised codes," CMS states in the final rule. The agency points to two other factors that are driving up charges for specialties seeing an increase, such as infectious disease and internal medicine: The revaluation of other E/M services and recent clinical labor pricing updates. "The services that make up these specialties rely primarily on E/M services or on clinical labor for their practice expense costs," CMS explains.

Just remember: The average projections "may not necessarily be representative of what is happening to the particular services furnished by a single practitioner within any given specialty," CMS says, and the ups or downs may not come to bear for your particular practice.

Source: Table 148, final 2023 Medicare physician fee schedule, www.cms.gov/files/document/cy2023-physician-fee-schedule-final-rule-cms-1770f.pdf ■