Issue Brief

FEDERAL ISSUE BRIEF • July 11, 2022

Proposed CY 2023 Revisions to Payment Policies under the Physician Fee Schedule Released

The Centers for Medicare and Medicaid Services (CMS) have issued a proposed rule to update the Medicare Physician Fee Schedule (MPFS) for CY 2023 that would be effective January 1,2023.

A copy of this massive 2,066-page rule is at the ***Federal Register*** office, and a copy is currently available at: https://public-inspection.federalregister.gov/2022-14562.pdf. The rule is scheduled for publication on July 29. A 60-day comment period is provided.

The PFS Addenda along with other supporting documents and tables referenced in the proposed rule are available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html. Click on the link on the left side of the screen titled, "PFS Federal Regulations Notices" for a chronological list of PFS Federal Register and other related documents. For the CY 2023 PFS proposed rule, refer to item CMS-1770-P.

COMMENT

The MPFS proposal is another extremely long and complex rule. Given CMS' propensity for rule's without a table of contents it is not surprising that such is totally missing.

Specifically, the rule says it includes discussions regarding the following. We have added page numbers to allow access to the material, and have used such as surrogate table of contents. Referenced page numbers in red are based on the Adobe page count of the regulation.

- Determination of PE RVUs (section II.B.) (Page 10)
- Potentially Misvalued Services Under the PFS (section II.C.) (Page 60)
- Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (section II.D.) (Page 76)
- Valuation of Specific Codes (section II.E.) (Page 116)
- Evaluation and Management (E/M) Visits (section II.F.) (Page 297)
- Geographic Practice Cost Indices (GPCI) (section II.G.) (Page 352)
- Determination of Malpractice Relative Value Units (RVUs) (section II.H.) (Page 387)
- Non-Face-to-Face/Remote Therapeutic Monitoring (RTM) Services (section II.I.) (Page 402)
- Payment for Skin Substitutes (section II.J.) (Page 413)
- Proposal to Allow Audiologists to Furnish Certain Diagnostic Tests

continued

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Without a Physician Order (section II.K.) (Page 422)

- Proposals and Request for Information on Medicare Parts A and B Payment for Dental Services (section II.L.) (Page 433)
- Rebasing and Revising the Medicare Economic Index (MEI) (section II.M.) (Page 458)
- Requiring Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts (§§ 414.902 and 414.940) (section III.A.) (Page 491)
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (section III.B.) (Page 515)
- Clinical Laboratory Fee Schedule: Revised Data Reporting Period and Phase-in of Payment Reductions, and Proposals for Specimen Collection Fees and Travel Allowance for Clinical Diagnostic Laboratory Tests (section III.C.) (Page 532)
- Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers (section III.D.) (Page 576)
- Removal of Selected National Coverage Determinations (section III.E.) (Page 592)
- Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs) (section III.F.) (Page 597)
- Medicare Shared Savings Program (section III.G.) (Page 615)
- Medicare Part B Payment for Preventive Vaccine Administration Services (section III.H.)
- (Page 983)
- Medical Necessity and Documentation Requirements for Nonemergency, Scheduled, Repetitive Ambulance Services (section III.I.) (Page 1,016)
- Medicare Provider and Supplier Enrollment and Conditions of DMEPOS Payment (section III.J.) (Page 1,024)
- State Options for Implementing Medicaid Provider Enrollment Affiliation Provision (section III.K.) (Page 1,044)
- Requirement for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan (section 2003 of the SUPPORT Act) (section III.L.) (Page 1,048)
- Medicare Ground Ambulance Data Collection System (GADCS) (section III.M.) (Page 1,060)
- Proposal to Revise HCPCS Level II Coding Procedures for Wound Care Management Products (section III.N.) (Page 1,084)
- Updates to the Quality Payment Program (section IV.) (Page 1,099)

Not all items in the proposal are addressed in the analysis that follows. Hopefully, the above page numbering can assist in determining the size (pages) of the issue being addressed.

Accounting Statement: Classification of Estimated Expenditures (Page 1,534)

CATEGORY TRA

Category	Transfers
CY 2023 Annualized Monetized Transfers	Estimated increase in expenditures of -$2.2 billion for PFS CF update
From Whom To Whom?	Federal Government to physicians, other practitionersand providers and suppliers who receive payment under Medicare.

continued

CMS is saying the rate of increase to physicians under the MPFS for CY 2023 will be a **negative $2.2 billion.**

The material that follows, with the exception of the proposed conversion factors, basically follows the organization of proposal.

I. PAYMENT PROVISIONS of the PROPOSED CY 2023 PFS RULE

Payment Updates and Conversion Factors (CF) (Page 1,438)
The PFS update adjustment factor for CY 2023, as specified in section 1848(d)(19) of the Act, is 0.00 percent before applying other adjustments. The ***Protecting Medicare and American Farmers from Sequester Cuts Act*** provided a 3.00 percent increase in PFS payment amounts for services furnished on or after January 1, 2022, and before January 1, 2023 and required that the increase not be taken into account in determining PFS payment rates for subsequent years. The expiration of this 3.00 percent increase in payment amounts will result in the CY 2023 conversion factor being calculated as though the 3.00 percent increase for the CY 2022 conversion factor had never been applied.

CMS estimates the CY 2023 PFS CF to be 33.0775 which reflects the budget neutrality (BN) adjustment under section 1848(c)(2)(B)(ii)(II) of the Act, the 0.00 percent update adjustment factor specified under section 1848(d)(19) of the Act, and the expiration of the 3.00 percent increase for services furnished in CY 2022. This is a decrease of $1.53 from the CY 2022 rate.

Calculation of the Proposed CY 2023 PFS Conversion Factor

CY 2022 Conversion Factor		34.6062
Conversion Factor without the CY 2022 Protecting Medicare and American Farmers from Sequester Cuts Act		33.5983
Statutory Update Factor	0.00 percent (1.0000)	
CY 2023 RVU Budget Neutrality Adjustment	-1.55 percent (0.9845)	
CY 2023 Conversion Factor		33.0775

CMS estimate the CY 2022 anesthesia CF to be 20.7191 which reflects the same overall PFS adjustments with the addition of anesthesia-specific PE and MP adjustments.

Calculation of the Proposed CY 2023 Anesthesia Conversion Factor

CY 2022 National Average Anesthesia Conversion Factor		21.5623
Conversion Factor without CY 2022 Protecting Medicare and American Farmers from Sequester Cuts Act		20.9343
Statutory Update Factor	0.00 percent (1.0000)	
CY 2023 RVU Budget Neutrality Adjustment	-1.55 percent (0.9845)	
CY 2023 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	0.53 percent (1.0053)	
CY 2023 Conversion Factor		20.7191

continued

The table below shows the payment impact by specialty of the policies contained in this proposed rule on PFS services. (Page 1,439)

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$232	0%	-1%		-2%
Anesthesiology	$1,741	-1%	0%	0%	-1%
Audiologist	$70	0%	1%	-1%	0%
Cardiac Surgery	$197	-1%	-1%	0%	-1%
Cardiology	$6,298	0%	-1%	0%	-1%
Chiropractic	$669	-1%	1%	0%	0%
Clinical Psychologist	$784	-1%	0%	-1%	-2%
Clinical Social Worker	$853	-1%	0%	-1%	-2%
Colon and Rectal Surgery	$155	-1%	-1%	0%	-1%
Critical Care	$351	1%	0%	1%	1%
Dermatology	$3,751	-1%	0%	0%	0%
Diagnostic Testing Facility	$811	0%	3%	0%	2%
Emergency Medicine	$2,530	0%	0%	1%	1%
Endocrinology	$532	0%	0%	0%	0%
Family Practice	$5,777	0%	0%	0%	0%
Gastroenterology	$1,589	0%	0%	1%	0%
General Practice	$371	0%	0%	0%	0%
General Surgery	$1,758	-1%	-1%	0%	-1%
Geriatrics	$175	2%	0%	0%	3%
Hand Surgery	$255	-1%	0%	0%	0%
Hematology/Oncology	$1,707	0%	-1%	0%	-1%
Independent Laboratory	$594	0%	-1%	0%	-1%
Infectious Disease	$586	4%	0%	1%	5%
Internal Medicine	$9,804	2%	0%	1%	3%
Interventional Pain Mgmt	$924	-1%	-1%	0%	-1%
Interventional Radiology	$465	-1%	-3%	0%	-4%
Multispecialty Clinic/Other Phys	$150	0%	-1%	0%	0%
Nephrology	$2,021	1%	0%	0%	1%
Neurology	$1,397	0%	0%	0%	-1%
Neurosurgery	$727	-1%	0%	1%	0%
Nuclear Medicine	$53	-1%	-1%	-1%	-3%
Nurse Anes / Anes Asst	$1,116	-1%	0%	0%	-1%
Nurse Practitioner	$5,802	1%	0%	0%	2%
Obstetrics/Gynecology	$592	-1%	0%	0%	-1%
Ophthalmology	$4,835	-1%	0%	0%	0%
Optometry	$1,306	-1%	0%	0%	-1%
Oral/Maxillofacial Surgery	$72	-1%	-1%	0%	-2%
Orthopedic Surgery	$3,461	-1%	0%	0%	0%
Other	$58	0%	-1%	0%	-2%
Otolaryngology	$1,134	-1%	0%	0%	-1%

continued

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Pathology	$1,163	-1%	0%	0%	-1%
Pediatrics	$57	0%	0%	0%	0%
Physical Medicine	$1,090	2%	0%	0%	2%
Physical/Occupational Therapy	$4,978	-1%	1%	-1%	-1%
Physician Assistant	$3,165	0%	0%	0%	0%
Plastic Surgery	$320	-1%	0%	0%	0%
Podiatry	$1,991	-1%	-1%	0%	-2%
Portable X-Ray Supplier	$77	0%	2%	0%	1%
Psychiatry	$978	1%	0%	0%	2%
Pulmonary Disease	$1,395	1%	0%	1%	2%
Radiation Oncology and Radiation Therapy Centers	$1,609	-1%	0%	0%	-1%
Radiology	$4,712	-1%	-1%	-2%	-3%
Rheumatology	$546	-1%	-1%	0%	-2%
Thoracic Surgery	$315	-1%	-1%	0%	-1%
Urology	$1,752	-1%	-1%	0%	-1%
Vascular Surgery	$1,098	0%	-3%	0%	-3%
Total	$90,953	0%	0%	0%	0%

Potentially Misvalued Services Under the PFS (Page 60)

CMS seeks additional comment and any independent analysis and studies listed under the "CY 2023 Identification and Review of Potentially Misvalued Services," particularly in regard to any changes in the resources to providing a service.

Interested Parties' Nominations of CPT Codes as Potentially Misvalued for CY 2023

CPT	CPT Descriptor
Home Health Visits	
99344	New patient home visit, typically 1 hour
99345	New patient home visit, typically 75 minutes
99349	Established patient home visit, typically 40 minutes
99350	Established patient home visit, typically 1 hour
Cataract Surgery codes:	
65820	Relieve inner eye pressure
66174	Translum dil eye canal
66982	Xcapsl ctrc rmvl cplx wo ecp
66984	Xcapsl ctrc rmvl cplx wo ecp
66989	Xcpsl ctrc rmvl cplx insj 1+
66991	Xcapsl ctrc rmvl insj 1+
Retina Procedure Codes	
67015	Release of eye fluid
67036	Removal of inner eye fluid
67039	Laser treatment of retina
67040	Laser treatment of retina
67041	Vit for macular pucker
67042	Vit for macular hole
67043	Vit for membrane dissect
67108	Repair detached retina
67113	Repair retinal detach cplx
Spinal Surgery Code	
20931	Allograft, structural, for spine surgery only (add-on code)

continued

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (Section II.D) (Page 76)

Changes
For CY 2023, CMS is proposing a number of policies related to Medicare telehealth services including making several services that are temporarily available as telehealth services for the public health emergency (PHE) period available through CY 2023 on a Category III basis, which, according to CMS will allow more time for collection of data that could support their eventual inclusion as permanent additions to the Medicare telehealth services list. CMS is proposing 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, including allowing Medicare telehealth services to be furnished to patients located anywhere within the U.S.; allowing the extended scope of eligible telehealth practitioners to include occupational therapists, physical therapists, speech-language pathologists, and audiologists; extending payment for telehealth services furnished by FQHCs and RHCs; and delaying the requirement that there be an in-person visit with the physician or practitioner within 6 months before an initial mental health telehealth service.

The Medicare Telehealth Services List requests for CY 2023 are listed in the proposal's Table 7. CMS notes that none of the requested services listed in Table 7 meet the Category 1 or 2 criteria. (Page 80)

CMS is proposing to add HCPCS CPT codes 97150, 97530, and 97542 to the Medicare Telehealth Services List on a Category 3 basis. CPT codes 97110, 97112, 97116, 97161 – 97164, 97535, 97750, and 97755 will continue to be available on the Medicare Telehealth Services List on a Category 3 basis.

Certain other requested therapy services, namely CPT codes 97537, 97763, 90901, and 98960-98962 are not currently on the Medicare Telehealth Services List; however, CMS is adding these services to the Medicare Telehealth Services List on a temporary basis during the PHE.

CMS is proposing to add CPT codes 95970, 95983, and 95984 to the Medicare Telehealth Services List on a Category 3 basis, while soliciting comments regarding patient safety and whether these services are appropriate for inclusion on the Medicare Telehealth Services List outside the circumstances of the PHE.

The rule's Table 8 lists the services that are being proposing for addition to the Medicare Telehealth
Services List on a Category 3 basis. Table 9 lists the services CMS is proposing for permanent addition to the Medicare Telehealth Services List on a Category 1 basis.

Services Proposed for Addition to the Medicare Telehealth Services List on a Category 3 Basis Through the End of CY 2023 (Page 101)

HCPCS	Short Descriptor
90875	Psychophysiological therapy
90901	Biofeedback train any meth
92012	Eye exam estab pat
92014	Eye exam & tx estab pt 1/>vst
92507	Speech/hearing therapy
92550	Tympanometry & reflex thresh
92552	Pure tone audiometry air
92553	Audiometry air & bone
92555	Speech threshold audiometry
92556	Speech audiometry complete
92557	Comprehensive hearing test
92563	Tone decay hearing test
92567	Tympanometry
92568	Acoustic refl threshold tst

continued

HCPCS	Short Descriptor
92570	Acoustic immitance testing
92587	Evoked auditory test limited
92588	Evoked auditory tst complete
92601	Cochlear implt f/up exam <7
92625	Tinnitus assessment
92626	Eval aud funcj 1st hour
92627	Eval aud funcj ea addl 15
94005	Home vent mgmt supervision
95970	Alys npgt w/o prgrmg
95983	Alys brn npgt prgrmg 15 min
95984	Alys brn npgt prgrmg addl 15
96105	Assessment of aphasia
96110	Developmental screen w/score
96112	Devel tst phys/qhp 1st hr
96113	Devel tst phys/qhp ea addl
96127	Brief emotional/behav assmt
96170	Hlth bhv ivntj fam wo pt 1st
96171	Hlth bhv ivntj fam w/o pt ea
97129	Ther ivntj 1st 15 min
97130	Ther ivntj ea addl 15 min
97150	Group therapeutic procedures
97151	Bhv id assmt by phys/qhp
97152	Bhv id suprt assmt by 1 tech
97153	Adaptive behavior tx by tech
97154	Grp adapt bhv tx by tech
97155	Adapt behavior tx phys/qhp
97156	Fam adapt bhv tx gdn phy/qhp
97157	Mult fam adapt bhv tx gdn
97158	Grp adapt bhv tx by phy/qhp
97537	Community/work reintegration
97542	Wheelchair mngment training
97530	Therapeutic activities
97763	Orthc/prostc mgmt sbsq enc
98960	Self-mgmt educ & train 1 pt
98961	Self-mgmt educ/train 2-4 pt
98962	Self-mgmt educ/train 5-8 pt
99473	Self-meas bp pt educaj/train
0362T	Bhv id suprt assmt ea 15 min
0373T	Adapt bhv tx ea 15 min

Services Proposed for Permanent Addition to the Medicare Telehealth Services List on a Category 1 Basis (Page 102)

HCPCS	Short Descriptor
GXXX1	Prolonged inpatient or observation services by physician or other QHP
GXXX2	Prolonged nursing facility services by physician or other QHP
GXXX3	Prolonged home or residence services by physician or other QHP

Services Proposed for Removal from the Medicare Telehealth Services List After 151 Days Following the End of the PHE (Page 103)

CMS is proposing to continue to include on the Medicare Telehealth Services List the services that are currently set to be removed from the list when the PHE ends (that is, those not currently added to the list on a Category 1, 2, or 3 basis) for an additional 151 days after the PHE ends. Refer rule's table 10. (Page 104)

Use of Modifiers for Medicare Telehealth Services Following the End of the PHE for COVID-19 (Page 109)

CMS proposes that Medicare telehealth services furnished on or before the 151st day after the end of the PHE, in alignment with the extensions of telehealth-related flexibilities in the CAA, 2022, will continue to be processed for payment as Medicare telehealth claims when accompanied with the modifier "95".

For Medicare telehealth services furnished on or after the 152nd day after the end of the PHE, the POS indicators for Medicare telehealth will be:

POS "02" - which would be redefined, if finalized, as Telehealth Provided Other than in Patient's Home (Descriptor: The location where health services and health related services are provided or received,

continued

through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.); and

POS "10" - Telehealth Provided in Patient's Home (Descriptor: The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.).

Beginning January 1, 2023, a physician or other qualified health care practitioner billing for telehealth services furnished using audio-only communications technology shall append CPT modifier "93"

Telehealth Originating Site Facility Fee Update (Page 115)

The proposed payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is $28.61.

Valuation of Specific Codes (Section II E.) (Page 116)

On an annual basis, the Specialty Society Relative Value Scale Update Committee (RUC) provides CMS with recommendations regarding PE inputs for new, revised, and potentially misvalued codes.

CMS explains changes it is making and, in many cases not making, to the specific CPT codes identified below.

In red, is the rule's display copy page number on which the code(s) discussions begin.

1	Anterior Abdominal Hernia Repair (CPT codes 157X1, 49X01, 49X02, 49X03, 49X04, 49X05, 49X06, 49X07, 49X08, 49X09, 49X10, 49X11, 49X12, 49X13, 49X14, and 49X15) (Page 131)
2	Removal of Sutures or Staples (CPT codes 15851, 158X1, and 158X2) (Page 140)
3	Arthrodesis Decompression (CPT codes 22630, 22632, 22633, 22634, 63052, and 63053) (Page 141)
4	Total Disc Arthroplasty (CPT codes 22857 and 228XX) (Page 147)
5	Insertion of Spinal Stability Distractive Device (CPT codes 22869 and 22870) (Page 147)
6	Knee Arthroplasty (CPT codes 27446 and 27447) (Page 148)
7	Endovascular Pulmonary Arterial Revascularization (CPT codes 338X3, 338X4, 338X5, 338X6, and 338X7)) (Page 149)
8	Percutaneous Arteriovenous Fistula Creation (CPT codes 368X1 and 368X2) (Page 151)
9	Energy Based Repair of Nasal Valve Collapse (CPT codes 37X01 and 30468) (Page 155)
10	Drug Induced Sleep Endoscopy (DISE) (CPT code 42975) (Page 156)
11	Endoscopic Bariatric Device Procedures (CPT codes 43235, 43X21, and 43X22) In February 2021, the CPT Editorial Panel created CPT codes 43X21 (Page 157)
12	Delayed Creation Exit Site from Embedded Catheter (CPT code 49436) (Page 159)
13	Percutaneous Nephrolithotomy (CPT codes 50080, 50081) (Page 160)
14	Laparoscopic Simple Prostatectomy (CPT codes 55821, 55831, 55866, and 558XX) (Page 162)
15	Lumbar Laminotomy with Decompression (CPT codes 63020, 63030, and 63035) (Page 163)
16	Somatic Nerve Injections (CPT codes 64415, 64416, 64417, 64445, 64446, 64447, 64448, 76942, 77002, and 77003) (Page 169)
17	Transcutaneous Passive Implant-Temporal Bone (CPT codes 69714, 69716, 69717, 69719, 69726, 69727, 69XX0, 69XX1, and 69XX2) (Page 177)
18	Contrast X-Ray of Knee Joint (CPT code 73580) (Page 182)

continued

19	3D Rendering with Interpretation and Report (CPT code 76377) (Page 182)
20	Neuromuscular Ultrasound (CPT codes 76881, 76882, and 76XX0) (Page 183)
21	Immunization Administration (CPT codes 90460, 90461, 90471, 90472, 90473, and 90474) (Page 189)
22	Orthoptic Training (CPT codes 92065 and 920XX) (Page 192)
23	Dark Adaptation Eye Exam (CPT code 92284) (Page 194)
24	Anterior Segment Imaging (CPT code 92287) (Page 195)
25	External Extended ECG Monitoring (CPT codes 93241, 93242, 93243, 93244, 93245, 93246, 93247, and 93248) (Page 195)
26	Cardiac Ablation (CPT codes 93653, 93654, 93655, 93656, and 93657) (Page 198)
27	Pulmonary Angiography (CPT codes 93XX0, 93XX1, 93XX2, 93XX3, 93563, 93564, 93565, 93566, 93567, and 93568) (Page 203)
28	Quantitative Pupillometry Services (CPT code 959XX) (Page 208)
29	Caregiver Behavior Management Training (CPT codes 96X70 and 96X71) (Page 210)
30	Cognitive Behavioral Therapy Monitoring (CPT code 989X6) (Page 212)
31	Code Descriptor Changes for Annual Alcohol Misuse and Annual Depression Screenings (HCPCS codes G0442 and G0444) (Page 212)
32	Insertion, and Removal and Insertion of new 180-Day Implantable Interstitial Glucose Sensor System (HCPCS codes G0308 and G0309) (Page 212)
33	Chronic Pain Management and Treatment (CPM) Bundles (HCPCS GYYY1, and GYYY2) (Page 214)
34	Proposed Revisions to the "Incident to" Physicians' Services Regulation for Behavioral Health Services (Page 233)
35	New Coding and Payment for General Behavioral Health Integration (BHI) billed by Clinical Psychologists (CPs) and Clinical Social Workers (CSWs) (Page 235)
36	Request for Information: Medicare Part B Payment for Services Involving Community Health Workers (CHWs) (Page 240)
37	Proposed Recognition of the Nurse Portfolio Credentialing Commission (NPCC) (Page 244)
38	Request for Information: Medicare Potentially Underutilized Services (Page 246)
39	Change in Procedure Status for Family Psychotherapy (Page 250)
40	Comment Solicitation on Intensive Outpatient Mental Health Treatment, including Substance Use Disorder (SUD) Treatment, Furnished by Intensive Outpatient Programs (IOPs) (Page 251)
41	Comment Solicitation on Payment for Behavioral Health Services under the PFS (Page 253)

COMMENT

Something appears amiss with respect to the following table descriptions. The table wordings say they reflect changes for CY 2022. However, the material pertains to the above CY 2023 items. One must assume the titles of the tables are in error. Nonetheless, we citing the information as presented.

The rule's table 12 beginning on page 255 contains the CY 2022 Work RVUs for New, Revised, and Potentially Misvalued Codes.

The rule's table 13 beginning on page 278 contains the CY 2022 Direct PE Refinements, also by HCPCS code.

The rule's table 14 beginning on page 291 contains the CY 2022 Direct PE Refinements – Equipment Refinements Conforming to Changes in Clinical Labor Time.

The rule's table 15 beginning on page 293 contains the CY 2022 Invoices Received for Existing Direct PE Inputs.

The rule's table 16 on page 294 contains the CY 2022 New Invoices.

The rule's table 17 on page 295 contains HCPCS codes that have No PE Refinements.

continued

Evaluation and Management (E/M) Visits (section II.F) (Page 297)

CMS says it is proposing to generally adopt the revised CPT E/M Guidelines for Other E/M visits, which are available online at: www.ama-assn.org/cpt-evaluation-management. Further, CMS proposes to adopt the general CPT framework for Other E/M visits, such that practitioner time or medical decision-making (MDM) would be used to select the E/M visit level.

Currently there are approximately 75 Other E/M CPT codes, and in 2023 there will be approximately 50 Other E/M CPT codes.

CMS notes that in total, E/M visits comprise approximately 40 percent of all allowed charges under the PFS. The subset of Other E/M visits comprises approximately 20 percent of all allowed charges.

CMS proposes to delay implementation of its policy to define the substantive portion of a split (or shared) visit at § 415.140 based on the amount of time spent by the billing practitioner. Clinicians who furnish split (or shared) visits will continue to have a choice of history, physical exam, or medical decision making, or more than half of the total practitioner time spent to define the substantive portion, instead of using total time to determine the substantive portion until CY 2024.

Coding Changes and Visit Selection for Hospital Inpatient or Observation Care Services
(Page 302)

The CPT Editorial Panel deleted the six codes that were used to report observation care visits: three initial observation care codes, CPT codes 99218, 99219 and 99220, and three subsequent observation care codes, CPT codes 99224, 99225 and 99226.

The CPT Editorial Panel changed the name of the "Hospital Inpatient Care" code family to "Hospital and Observation Care," and the new code family includes three initial hospital or observation care codes: CPT 99221, 99222 and 99223, and three subsequent inpatient or observation care codes, CPT codes 99231, 99232 and 99233.

Proposed "8 to 24 Hour Rule" for Hospital Inpatient or Observation Care (Page 307)

CMS proposes to retain what is known as the "8 to 24-hour rule" regarding payment of discharge CPT codes 99238 (Hospital inpatient or observation discharge day management; 30 minutes or less) and 99239 (more than 30 minutes).

Proposed Definition of Initial and Subsequent Hospital Inpatient or Observation Visit
(Page 309)

CMS is proposing to slightly amended definitions of "initial" and "subsequent" service:

An initial service would be defined as one that occurs when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the same specialty who belongs to the same group practice during the stay.

A subsequent service would be defined as one that occurs when the patient has received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the same specialty who belongs to the same group practice during the stay.

continued

Transitions Between Settings of Care and Multiple Same-Day Visits for Hospital Patients Furnished by a Single Practitioner (Page 310)

CMS proposes to preserve its current billing policies for patients in swing beds, which are as follows: If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes (CPT codes 99221 through 99223 and 99231 through 99239) apply. If the inpatient care is being billed by the hospital as nursing facility care, then the nursing facility codes (CPT codes 99304 through 99316) apply.

Impact of Changes to Hospital Inpatient or Observation Codes on Billing and Claims Processing Policies (page 312)

Starting in CY 2023, hospital inpatient and observation care by physicians will be billed using the same CPT codes, CPT codes 99221 through 99223, 99231 through 99233, and 99238 and 99239.

The current observation care codes (CPT codes 99218 through 99220 and 99224 through 99226) are being deleted.

Prolonged Services for Hospital Inpatient or Observation Care (Page 313)

CMS is proposing to create a single G-code that describes a prolonged service, and that applies to CPT codes 99223, 99233, and 99236. This G-code would be GXXX1.

Refer to summary Table 18 in the section "Prolonged Services Valuation" (section II.F.11.e. of the proposed rule) for a chart showing the proposed billing timeframe for GXXX1. (Page 347)

Valuation of Hospital Inpatient or Observation Care Services (Page 318)

CMS is proposing to accept the RUC recommendations for work RVUs and times for CPT codes 99221 (work RVU 1.63, intra-service time 40 minutes, total time 40 minutes); 99222 (work RVU 2.60, intra-service time 55 minutes, total time 55 minutes); 99223 (work RVU of 3.50, intra-service time 74 minutes, total time 74 minutes); 99231 (work RVU 1.00, intra-service time 25 minutes, total time 25 minutes), 99232 (work RVU 1.59, intra-service time 36 minutes, total time 36 minutes); 99233 (work RVU 2.40, intra-service time 52 minutes, total time 52 minutes); 99234 (work RVU 2.00, intra-service time 45 minutes, total time 50 minutes); 99235 (work RVU 3.24, intra-service time 68 minutes, total time 76 minutes); and 99236 (work RVU 4.30, intra-service time 85 minutes, total time 97 minutes).

Valuation (Page 325)

CMS is proposing a work RVU of 0.25 for CPT code 99281 (Emergency department visit), a work RVU of 0.93 for CPT code 99282; a work RVU of 1.60 for CPT code 99283; and a work RVU of 4.00 for CPT code
99285.

For CPT code 99284 (Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making) and CMS is proposing to maintain the current work RVU of 2.74.

COMMENT

The above material regarding E/M visits is extremely code intensive. There is much more information in the proposal than can reflected in this analysis. The E/M section is more than 50 pages in length.

Geographic Practice Cost Indices (GPCIs) (section II G) (Page 352)

CMS is proposing new GPCIs beginning for CY 2023.

continued

See Addenda D and E for the proposed GPCIs and summarized geographic adjustment factors (GAFs). These Addenda are available on the CMS website under the supporting documents section of the CY 2023 PFS at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html.

Determination of Malpractice Relative Value Units (RVUs) (section II.H) (Page 387)

For the CY 2020 update of MP RVUs CMS finalized a policy to align the update of MP premium data with the update to the MP GPCIs "to increase efficiency." Effective beginning in CY 2020, CMS' policy is to review, and if necessary update, the MP RVUs at least every 3 years, similar to its review and update of the GPCIs.

CMS says it now has specialty-specific data for many more specialties. However, although the newly captured specialty-specific premium data are more accurate, the new data produce premiums and risk index values that are significantly lower for some specialties than the ones CMS applied in the absence of sufficient specialty-specific data.

CMS proposes to phase in the reduction in MP RVUs over 3 years rather than 2 years because the MP risk index values are updated every 3 years.

The corresponding risk index values for each specialty is available on the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.

Non-Face-to-Face Services/Remote Therapeutic Monitoring (RTM)Services (section II.I) (Page 402)

Remote Therapeutic Monitoring (RTM) is a family of five codes. The RTM codes include three PE-only codes and two professional work, treatment management codes.

For CY 2023 CMS is proposing to create four new HCPCS G codes with one pair of codes aimed at increasing patient access to remote therapeutic monitoring services and the second pair aimed at reducing physician and NPP supervisory burden.

Summary of Proposed HCPCS G Codes for Remote Therapeutic Monitoring Services (Page 409)

HCPCS Code	Code Descriptor	Global Period	Work RVU Recommendation
GRTM1	Remote therapeutic monitoring treatment management services, physician or NPP professional time over a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes (Report GRTM1 once each 30 days, regardless of the number of parameters remotely monitored) (CPT codes 98975 and 98976 or 98977 must be billed prior to reporting GRTM1 and GRTM2) (At least 16 days of data must be reported) (Do not report GRTM1 for services less than 20 minutes) (Do not report GRTM1 in conjunction with 93264, 99457, 99458, 98980, 98981, GRTM3, GRTM4) (Do not report GRTM1 in the same calendar month as 99473, 99474)	XXX	0.62

continued

HCPCS Code	Code Descriptor	Global Period	Work RVU Recommendation
GRTM2	Remote therapeutic monitoring treatment management services, physician or NPP professional time over a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure) (Use GRTM2 in conjunction with GRTM1) (CPT codes 98975 and 98976 or 98977 must be billed prior to reporting GRTM1 and GRTM2) (Do not report GRTM2 for services less than of 20 minutes) (Do not report GRTM2 in conjunction with 93264, 99457, 99458, 98980, 98981, GRTM3, GRTM4)	ZZZ	0.61
GRTM3	Remote therapeutic monitoring treatment assessment services, first 20 minutes furnished personally/directly by a nonphysician qualified health care professional over a calendar month requiring at least one interactive communication with the patient/caregiver during the month (Report GRTM3 once each 30 days, regardless of the number of parameters remotely monitored) (CPT codes 98975 and 98976 or 98977 must be billed prior to reporting GRTM3 and GRTM4) (At least 16 days of data must be reported) (Do not report GRTM3 for services less than 20 minutes) (Do not report GRTM3 in conjunction with 93264, 99457, 99458. 98980, 98981, GRTM1, GRTM2) (Do not report GRTM3 in the same month as 99473, 99474)	XXX	0.62
GRTM4	Remote therapeutic monitoring treatment assessment services, each additional 20 minutes furnished personally/directly by a nonphysician qualified health care professional over a calendar month requiring at least one interactive communication with the patient/caregiver during the month (List separately in addition to code for primary procedure) (Use GRTM4 in conjunction with GRTM3) (CPT codes 98975 and 98976 or 98977 must be billed prior to reporting GRTM3 and GRTM4) (Do not report GRTM4 for services less than 20 minutes) (Do not report GRTM4 in conjunction with 93264, 99457, 99458, 98980, 98981, GRTM1, GRTM2)	ZZZ	0.61

Payment for Skin Substitutes (section II.J) (Page 413)

In the CY 2022 PFS final rule, CMS finalized an approach for payment of synthetic skin substitutes in the physician office setting. CMS announced that it had established a unique HCPCS code for each of ten products. The ten products are as follows: NovoSorb® SynPath™, Restrata® Wound Matrix, Symphony™, InnovaMatrix™ AC, Mirragen® Advanced Wound Matrix, bio-ConneKt® Wound Matrix, TheraGenesis®, XCelliStem®, Microlyte® Matrix, and Apis®.

CMS is proposing to change the terminology of skin substitutes to "wound care management products" in order to accurately reflect how clinicians use these products, to provide a more consistent and transparent approach to coding for these products, and to treat and pay for these products as incident to supplies under the PFS beginning on January 1, 2024.

continued

CMS is proposing that skin substitute products that are commonly furnished in the physician office setting be considered as incident to, effective January 1, 2024. CMS would no longer pay separately for skin substitute products under the ASP+6 Percent payment methodology.

Proposal to Allow Audiologists to Furnish Certain Diagnostic Tests Without a Physician Order (section II.K) (Page 422)

CMS is proposing to create HCPCS code GAUDX (Audiology service(s) furnished personally by an audiologist without a physician/NPP order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids or examinations for the purpose of prescribing, fitting, or changing hearing aids; (service may be performed once every 12 months) to describe these audiology services furnished personally by an audiologist without the order of the treating physician or other practitioner.

Proposals and Request for Information on Medicare Parts A and B Payment for Dental Services (section II.L) (Page 433)

CMS is proposing to amend § 411.15(i) to codify that payment can be made under Medicare Part A and Part B for dental services that are inextricably linked to, and substantially related and integral to the clinical success of, an otherwise covered medical service.

- Dental or oral examination as part of a comprehensive workup prior to a renal organ transplant surgery;
- Reconstruction of a dental ridge performed as a result of and at the same time as the surgical removal of a tumor;
- Wiring or immobilization of teeth in connection with the reduction of a jaw fracture;
- Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease; and
- Dental splints only when used in conjunction with medically necessary treatment of a medical condition.

Further, CMS proposes that Medicare payment would be made for these dental services regardless of whether the services are furnished in an inpatient or outpatient setting, and CMS proposes that payment can also be made for services that are ancillary to these dental services, such as x-rays, administration of anesthesia, use of an operating room, other facility services.

Rebasing and Revising the Medicare Economic Index (MEI) (section II.M) (Page 458)

The MEI is a fixed-weight input price index comprised of two broad categories: (1) Physicians' own time (compensation); and (2) physicians' practice expense (PE). Additionally, it includes an adjustment for the change in economy-wide, private nonfarm business total factor productivity (previously referred to as multifactor productivity).

CMS is proposing to rebase and revise the MEI based on a methodology that uses publicly available data sources for input costs that represent all types of physician practice ownership; that is, not limited to only self-employed physicians.

While the MEI annual percentage change increase is not directly used in determining the update to the PFS CF, the MEI cost weights have historically been used to update the GPCI cost share weights to weigh the four components of the practice expense GPCI (employee compensation, the office rent, purchased services, and medical equipment, supplies, and other miscellaneous expenses).

The table below lists the set of mutually exclusive and exhaustive cost categories and weights for the proposed 2017-based MEI compared to the 2006-based MEI.

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Proposed 2017-based MEI and 2006-based MEI Cost Categories and Weights

Cost Category	Proposed 2017-based	Current 2006-based
MEI Total	100.000%	100.000%
Physician Compensation	47.261%	50.866%
Wages and Salaries	39.226%	43.641%
Benefits	8.034%	7.225%
Practice Expense	52.739%	49.134%
Non-physician Compensation	24.716%	16.553%
Non-physician Wages	20.514%	11.885%
Non-health, Non-physician Wages	12.306%	7.249%
Professional and Related	1.381%	0.800%
Management	2.171%	1.529%
Clerical	7.947%	4.720%
Services	0.807%	0.200%
Health related, Non-physician Wages	8.208%	4.636%
Non-physician Benefits	4.202%	4.668%
Other Practice Expense	28.024%	32.582%
Utilities	0.366%	1.266%
All Other Products	2.055%	2.478%
Telephone	0.471%	1.501%
Postage	-	0.898%
All Other Professional Services	13.914%	8.095%
Professional, Scientific, and Tech. Services	6.350%	2.592%
Administrative & Waste Services	2.341%	3.052%
All Other Services	5.223%	2.451%
Capital	7.748%	10.310%
Fixed Capital	5.527%	8.957%
Moveable Capital (including medical)	2.221%	1.353%
Professional Liability Insurance	1.398%	4.295%
Medical Equipment	-	1.978%
Medical Supplies	2.071%	1.760%

II. Other Provisions of the Proposed Rule

Requiring Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts (§§ 414.902 and 414.940) (section III.A)
(Page 491)

Section 90004 of the ***Infrastructure Investment and Jobs Act*** amended section 1847A of the Act adding provisions that require manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug. The refund amount is the amount of discarded drug that exceeds an applicable percentage, which is required to be at least 10 percent, of

continued

total allowed charges for the drug in a given calendar quarter. The proposals to implement section 90004 include: how discarded amounts of drugs are determined; a definition of which drugs are subject to refunds (and exclusions); when and how often CMS will notify manufacturers of refunds; when and how often payment of refunds from manufacturers to CMS is required; refund calculation methodology (including applicable percentages); a dispute resolution process; and enforcement provisions.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)(section III.B) (Page 515)

RHCs generally are paid an all-inclusive rate (AIR) for all medically necessary medical and mental health services and qualified preventive health services furnished on the same day (with some exceptions).

HCPCS code G0511 is a General Care Management code for use by RHCs or FQHCs when at least 20 minutes of qualified Chronic Care Management(CCM) or general Behavioral Health Integration (BHI) services are furnished to a patient in a calendar month.

Starting on January 1, 2019, RHCs and FQHCs were paid for HCPCS code G0511 based on the average of the national non-facility PFS payment rates for CPT codes 99490, 99487, 99484, and 99491. For CY 2022 the current payment rate for HCPCS G0511 is the average of the national non-facility PFS payment rate for the RHC and FQHC care management and general behavioral health codes (CPT codes 99490, 99487, 99484, and 99491), and Principle Care Management (PCM) codes (CPT codes 99424 and 99425).

CMS is proposing to include Chronic Pain Management (CPM) services in the general care management HCPCS code G0511 when these services are provided by RHCs and FQHCs. Since HCPCS code GYYY1 would be valued using a crosswalk to the General Behavioral Health Integration (GBHI) PCM CPT code 99424, which is currently one of the CPT codes that comprise HCPCS code G0511. CMS proposes no change to the average used to calculate the G0511 payment rate.

If finalized as proposed, RHCs and FQHCs that furnish the new CPM and GBHI services performed by clinical psychologists (CPs) and clinical social workers (CSWs) would be able to bill these services using HCPCS code G0511, either alone or with other payable services on an RHC or FQHC claim for dates of service on or after January 1, 2023.

Clinical Laboratory Fee Schedule: Revised Data Reporting Period and Phase-in of Payment Reductions, and Proposals for Specimen Collection Fees and Travel Allowance for Clinical Diagnostic Laboratory Tests (section III.C) (Page 532)

CMS is proposing to revise § 414.502 to update the definitions of both the "data collection period" and "data reporting period," specifying that for the data reporting period of January 1, 2023 through March 31, 2023, the data collection period is January 1, 2019 through June 30, 2019. CMS is also proposing to revise § 414.504(a)(1) to indicate that initially, data reporting begins January 1, 2017 and is required every 3 years beginning January 2023.

In addition, CMS is proposing to make conforming changes to its requirements for the phase-in of payment reductions to reflect the amendments in section 4(b) of the ***Protecting Medicare and American Farmers from Sequester Cuts Act*** (PMAFSCA). Specifically, CMS is proposing to revise § 414.507(d) to indicate that for CY 2022, payment may not be reduced by more than 0 percent as

continued

compared to the amount established for CY 2021, and for CYs 2023 through 2025, payment may not be reduced by more than 15 percent as compared to the amount established for the preceding year.

CMS is proposing to codify and clarify various laboratory specimen collection fee policies in § 414.523(a)(1). This is because the policies implementing the statutory requirements under section 1833(h)(3)(A) of the Act for the laboratory specimen collection fee, which are currently described in the Medicare Claims Processing Manual Pub. 100-04, chapter 16, § 60.1., do not have corresponding regulations text and some of the manual guidance is no longer applicable.

CMS is proposing to codify in its regulations to the Medicare CLFS travel allowance policies. CMS is proposing to add § 414.523(a)(2) "Payment for travel allowance" to reflect the requirements for the travel allowance for specimen collection. Specifically, in accordance with section 1833(h)(3)(B) of the Act, CMS is proposing to include in its regulations the following requirements for the travel allowance methodology: (1) general requirements, (2) travel allowance basis, (3) travel allowance amount, and (4) travel allowance amount calculation.

Expansion of Coverage for Colorectal Cancer (CRC) Screening and Reducing Barriers (section III.D) (Page 576)

CMS is proposing to expand Medicare coverage of certain CRC screening tests by reducing the minimum age payment limitation to 45 years in its regulations at § 410.37 and in national coverage decisions (NCD) 210.3.

In addition, CMS proposes to expand the regulatory definition of CRC screening tests to include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based CRC screening test returns a positive result.

Removal of Selected National Coverage Determinations (section III.E) (Page 592)

The current NCD is available in the Medicare National Coverage Determinations Manual located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/internet-Only-Manuals-IOMs-Items/CMS014961.

CMS is soliciting comments on its proposal to remove NCD 160.22 Ambulatory EEG Monitoring.

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs) (section III.F) (Page 597)

CMS is proposing to revise its methodology for pricing the drug component of the methadone weekly bundle and the add-on code for take-home supplies of methadone. Under this proposal, CMS would base the payment amount for the drug component of HCPCS codes G2067 and G2078 for CY 2023 and subsequent years on the payment amount for methadone in CY 2021 and update this amount annually to account for inflation using the Producer Price Index (PPI) for Pharmaceuticals for Human Use (Prescription).

The proposed CY 2023 methadone payment amount would be $39.29, which is the CY 2022 payment amount of $37.38 increased by a projected 5.1 percent growth in the PPI for Pharmaceuticals for Human Use (Prescription) from CY 2021 to CY 2023 ($37.38 * 1.051 = $39.29).

CMS is proposing to modify the payment rate for the non-drug component of the bundled payments for episodes of care to base the rate for individual therapy on a crosswalk code describing a 45-minute

continued

session, rather than the current crosswalk to a code describing a 30-minute session.

CMS is also proposing to allow the OTP intake add-on code to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with buprenorphine, to the extent that the use of audio-video telecommunications technology to initiate treatment with buprenorphine is authorized by the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) at the time the service is furnished. CMS is also proposing to permit the use of audio-only communication technology to initiate treatment with buprenorphine in cases where audio-video technology is not available to the beneficiary and all other applicable requirements are met.

Medicare Shared Savings Program (section III.G) (Page 615)

This section is 368 pages. The following material is from a CMS' fact sheet on the subject.

"This fact sheet summarizes the major proposed changes to the Shared Savings Program that are included in the CY 2023 PFS proposed rule, and select issues on which we seek comment."

Increasing Participation in Accountable Care Models in Underserved Communities by Providing an Option for Advance Investment Payments to Certain ACOs

Advance Investment Payments

CMS is proposing to incorporate an option into the Shared Savings Program to make advance shared savings payments to certain ACOs. The expectation is that this proposal, if finalized, would be 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. Under the proposed approach, an eligible ACO that is new to the Shared Savings Program (that is, not a renewing ACO or a re-entering ACO), and identified as being low revenue and inexperienced with performance-based risk Medicare ACO initiatives, may receive a one-time fixed payment of $250,000 and quarterly payments for the first two years of the 5-year agreement period.

ACOs must use advance investment payments to improve health care provider infrastructure, increase staffing, or provide accountable care for underserved beneficiaries, which may include addressing social needs. ACOs would also publicly report on their website the amount of any advance investment payments and the actual amount spent in each of the spend plan categories. CMS proposes the initial application cycle to apply for advance investment payments will occur during CY 2023 for a January 1, 2024, start date.

Smoothing the Transition to Performance-Based Risk

For agreement periods beginning on January 1, 2024, and in subsequent years, CMS is proposing to allow ACOs inexperienced with performance-based risk to participate in one 5-year agreement under a one-sided shared savings model only by entering the BASIC track's glide path and remaining in Level A for all 5 years.

CMS says this proposal is responsive to interested parties' concerns that particularly smaller providers in rural and underserved settings need additional

continued

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.

Strengthening Program Participation by Reducing the Effect of ACO Performance on Historical Benchmarks, Addressing Market Penetration, Strengthening Incentives for ACOs Serving Medically Complex and High Cost of Care Populations

CMS proposes a combination of policies to ensure a robust benchmarking methodology that would reduce the effect of ACO performance on ACO historical benchmarks and increase options for ACOs caring for high-risk populations, specifically to: 1) modify the methodology for updating the historical benchmark to incorporate a prospective, external factor, 2) incorporate a prior savings adjustment in historical benchmarks for renewing and re-entering ACOs, and 3) reduce the impact of the negative regional adjustment.

These proposed changes, and the other proposed changes to the Shared Savings Program's benchmarking methodology within this proposed rule, would be applicable to establishing, updating, and adjusting the benchmark for agreement periods beginning on January 1, 2024, and in subsequent years.

Incorporating a Prospective, External Factor in Growth Rates Used to Update the Historical Benchmark

CMS is proposing to incorporate a prospectively projected administrative growth factor, a variant of the United States Per Capita Cost (USPCC) referred to as the Accountable Care Prospective Trend (ACPT), into a three-way blend with national and regional growth rates to update an ACO's historical benchmark for each performance year (PY) in the ACO's agreement period. CMS notes that incorporating this prospective trend in the update to the benchmark would insulate a portion of the annual update from any savings occurring as a result of the actions of ACOs participating in the Shared Savings Program and address the impact of increasing market penetration by ACOs in a regional service area on the existing blended national-regional growth factor.

A three-way blend would be calculated as the weighted average of the ACPT (one-third) and the existing national-regional blend (two-thirds) for use in updating an ACO's historical benchmark between benchmark year (BY) 3 and the payment year (PY). The ACPT would be projected by the CMS Office of the Actuary (OACT) and would be a modification of the existing FFS USPCC growth trend projections used annually for establishing Medicare Advantage rates, excluding indirect medical education (IME), and disproportionate share hospital (DSH) payments, and the proposed new supplemental payment for Indian Health Service (IHS)/Tribal Hospitals and hospitals located in Puerto Rico, and including payments associated with hospice claims to be consistent with Shared Savings Program's expenditure calculations.

Adjusting ACO Benchmarks to Account for Prior Savings

CMS is proposing to incorporate an adjustment for prior savings that would apply in the establishment of benchmarks for renewing ACOs and re-entering ACOs, that were reconciled for one or more performance years in the three years preceding the start of their agreement period. Such an adjustment would help to mitigate the rebasing ratchet effect on an ACO's benchmark by returning to an ACO's benchmark an amount that reflects its success in lowering growth in

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expenditures while meeting the program's quality performance standard in the performance years corresponding to the benchmark years for the ACO's new agreement period.

Reducing the Impact of the Negative Regional Adjustment

CMS proposes to institute two policy changes designed to limit the impact of negative regional adjustments on ACO historical benchmarks and further incentivize program participation among ACOs serving high-cost beneficiaries. CMS proposes to reduce the cap on negative regional adjustments from a negative 5.0 percent of national per capita expenditures for Parts A and B services under the original Medicare FFS program in base year (BY) 3 for assignable beneficiaries to negative 1.5 percent. CMS also proposes that after the cap is applied to the regional adjustment, to gradually decrease the negative regional adjustment amount as an ACO's proportion of dual eligible Medicare and Medicaid beneficiaries increases or its weighted-average prospective Hierarchical Condition Category (HCC) risk score increases.

Calculating County FFS Expenditures to Reflect Differences in Prospective Assignment and Preliminary Prospective Assignment with Retrospective Reconciliation

CMS is proposing to calculate risk adjusted regional expenditures using county-level values computed using an assignment window that is consistent with an ACO's assignment methodology selection for the performance year. That is, for ACOs selecting prospective assignment, CMS would use an assignable population of beneficiaries that is identified based on the offset assignment window (for example, October through September preceding the calendar year) and for ACOs selecting preliminary prospective assignment with retrospective reconciliation, CMS would continue to use an assignable population of beneficiaries that is identified based on the calendar year assignment window. To facilitate modeling of the proposed changes, CMS is making available, through the Shared Savings Program website at www.cms.gov/sharedsavingsprogram/ the following data files: risk adjusted county-level FFS expenditures for 2018-2020 calculated based on an assignable population identified using an offset assignment window; and data files with ACO-specific information on the applicable assignment methodology for the corresponding years.

Improving the Risk Adjustment Methodology to Better Account for Medically Complex, High-Cost Beneficiaries and Guard Against Coding Initiatives

Currently, for ACOs in agreement periods beginning on or after July 1, 2019, CMS uses prospective HCC risk scores to adjust the ACO's historical benchmark at the time of reconciliation for a performance year to account for changes in severity and case mix for the ACO's assigned beneficiary population between BY3 and the performance year, subject to a cap of positive 3.0 percent for the agreement period (referred to herein as the "3 percent cap"). Currently, the 3.0 percent cap is applied separately for the population of beneficiaries in each Medicare enrollment type (ESRD, disabled, aged/dual eligible Medicare and Medicaid beneficiaries, and aged/non-dual eligible Medicare and Medicaid beneficiaries). That is, any positive adjustment between BY3 and any performance year in the agreement period cannot be larger than 3.0 percent for any Medicare enrollment type.

CMS is proposing to modify the existing 3.0 percent cap on positive prospective HCC risk score growth, such that an ACO's aggregate prospective HCC

continued

risk score would be subject to a cap equal to the ACO's aggregate growth in demographic risk scores between BY3 and the performance year plus 3.0 percentage points. In other words, CMS would calculate a single aggregate value for the cap equal to the dollar-weighted average growth in demographic risk scores across the four enrollment types plus 3.0 percentage points. CMS would only apply this cap to prospective HCC risk score growth for a particular enrollment type if the aggregate growth in prospective HCC risk scores, calculated as the dollar-weighted average growth in prospective HCC risk scores across the four enrollment types, exceeds the value of the cap. CMS says it believes that these changes to the risk adjustment methodology would address several of the concerns raised by interested parties: account for higher volatility in risk scores for certain enrollment types due to smaller sample sizes; allow for higher benchmarks than the current methodology for ACOs that care for larger proportions of beneficiaries in dually eligible, disabled and ESRD enrollment types (which are more frequently subject to the cap on risk score growth currently); and continue to safeguard the Trust Funds by limiting returns from coding initiatives.

Increased Opportunities for Low Revenue ACOs to Share in Savings

CMS is proposing to expand the eligibility criteria to qualify for shared savings for agreement periods beginning on January 1, 2024, and in subsequent years, 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. Eligible ACOs that meet the quality performance standard required to share in savings at the maximum sharing rate would receive half of the maximum sharing rate for their level of participation (20.0 percent instead of 40.0 percent under Levels A and B, and 25.0 percent instead of 50.0 percent under Levels C, D, and E). For eligible ACOs that do not meet the quality performance standard required to share in savings at the maximum sharing rate but meet the proposed alternative quality performance standard, the sharing rate would be further adjusted according to a proposed 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. This modification would also align with the other changes CMS is proposing to encourage participation by new ACOs and ACOs that focus on underserved populations, such as the proposal to offer advance investment payments to new low revenue ACOs joining the BASIC track.

Transitioning ACOs to All Payer Quality Measure Reporting, Adjusting for Health Equity, and Addressing Social Determinants of Health

Proposal to Use a Sliding Scale Approach for Determining Shared Savings and Scaled Losses Beginning in Performance Year 2023 and Extend the Incentive for Reporting eCQMs/MIPS CQMS for Performance Year 2024

Beginning on January 1, 2023, and subsequent years, CMS is proposing to change the all-or-nothing approach to determining an ACO's eligibility for shared savings based on quality performance to allow for scaling of shared savings rates for ACOs that fall below the 30th/40th percentile quality standard threshold required to share in savings at the maximum sharing rate, but who meet minimum quality reporting and performance requirements. Under the

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proposal, an ACO's quality score for a performance year and the determination of whether the ACO met the Shared Savings Program quality performance standard would affect the determination of shared savings for that performance year and, for ACOs participating in the ENHANCED track, the amount of any shared losses owed.

CMS is proposing that, beginning with performance year 2023 and for subsequent performance years, if an ACO fails to meet the existing criteria under the quality performance standard to qualify for the maximum sharing rate but the ACO achieves a quality performance score equivalent to or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set then the ACO would share in savings (if otherwise eligible) at a lower rate that reflects the ACO's quality performance category score. The intent of this proposal is to lead to more predictable savings, avoid a cliff whereby small differences in quality scores would lead to elimination of all shared savings, and to promote quality improvement to drive high-quality care for all people with Medicare that receive care at ACOs.

Proposal to Implement a Health Equity Adjustment

CMS is proposing to implement a health equity adjustment of up to 10 bonus points to an ACO's MIPS quality performance category score when reporting all-payer eCQMs/MIPS CQMs and based on (1) high quality measure performance and (2) providing care for a higher proportion of underserved or dually eligible beneficiaries. CMS proposes to 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. The proposal would add bonus points to the ACO's MIPS quality performance category score if the ACO scores in the top third or middle third of performance for each quality measure. This proposal would only positively impact ACOs and not penalize them.

Proposed Benchmarking Policies for CMS Web Interface Measures for Performance Years 2022, 2023, and 2024

CMS is proposing to amend the regulation at § 425.512, which governs the ACO quality performance standard for performance years beginning on or after January 1, 2021, to include a new paragraph (a)(6), which will provide that for performance years 2022, 2023, and 2024, CMS designates a performance benchmark and minimum attainment level for each CMS Web Interface measure and establishes a point scale for the measure as described in § 425.502(b). In addition, CMS is proposing to use the approach to set flat percentage benchmarks for the Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID 134) measure and score the Preventative Care and Screening: Tobacco Use: Screening and Cessation Intervention (Quality ID# 226) measure using flat percentage benchmarks for performance year 2022.

Reducing Administrative Burden for ACOs

Marketing Materials

CMS is proposing to remove the requirement for ACOs to submit marketing materials for CMS review prior to use. This change would be effective for performance years beginning January 1, 2023, and for subsequent years.

continued

Beneficiary Notifications

CMS is proposing to modify the requirement for ACOs to provide a beneficiary notice prior to or at the first primary care service visit annually to providing the notice prior to or at the first primary care service visit once per agreement period, with a follow-up beneficiary communication taking place within 180 days after the beneficiary notice is provided, effective for performance years beginning January 1, 2023 and in subsequent years.

SNF 3-day Rule Waiver Application

CMS proposes to remove the requirement for ACOs applying for the SNF 3-Day Rule Waiver to provide narratives describing its communication plan, care management plan, and beneficiary evaluation and admission plan. For performance years beginning January 1, 2024, and subsequent years, CMS proposes to require ACOs to submit attestations that they have established the relevant plans.

Data Sharing

CMS is proposing to update data sharing regulations to add that ACOs acting as organized health care agreements (OHCAs) may request aggregate reports and beneficiary-identifiable claims data from CMS, and indicate ACOs may choose to structure themselves as OHCAs in order to reduce burden with reporting eCQMs/ MIPS CQMs. This is proposed to be effective for performance years beginning January 1, 2023, and subsequent years.

Updates to ACO Beneficiary Assignment Methodology

CMS is proposing revisions to the definition of primary care services that are used for purposes of beneficiary assignment including to incorporate new prolonged services codes and new chronic pain management codes to ensure that the Shared Savings Program assignment methodology remains consistent with billing and coding guidelines. These proposed changes would be applicable for the performance years starting on January 1, 2023, and in subsequent years.

[End of Shared Services Provisions]

Medicare Part B Payment for Preventive Vaccine Administration Services (section III.H) (Page 983)

Under section 1861(s)(10) of the Act, Medicare Part B covers both the vaccine and its administration for the specified preventive vaccines – the influenza, pneumococcal, and hepatitis B virus (HBV) vaccines.

CMS is proposing a geographic adjustment policy that would apply to preventive vaccine administration services for CY 2023 and subsequent years. CMS proposes to use the GAFs to adjust payment for the preventive vaccine administration services for geographic cost differences beginning for CY 2023.

For CY 2023 CMS proposes to continue the additional payment of $35.50 when a COVID–19 vaccine is administered in a beneficiary's home.

CY 2023 Part B Payment for Preventive Vaccine Administration if the Emergency Use Authorization (EUA) Declaration Persists into CY 2023

continued

Category of Part B Product Administration	Part B Payment Amount (Unadjusted)	Annual Adjustment?	Geographic Adjustment ?
Influenza, Pneumococcal, Hepatitis B Vaccines[1,4]	$30	MEI	GAF
COVID-19 Vaccine[2,4]	$40	MEI	GAF
COVID-19 Monoclonal Antibodies (for Treatment or Post-Exposure Prophylaxis)[3]			
Infusion: Health Care Setting	$450.00	N/A	GAF
Infusion: Home	$750.00	N/A	GAF
Intravenous Injection: Health Care Setting	$350.50	N/A	GAF
Intravenous Injection: Home	$550.50	N/A	GAF
Injection: Health Care Setting	$150.50	N/A	GAF
Injection: Home	$250.50	N/A	GAF
COVID-19 Monoclonal Antibodies (for Pre-Exposure Prophylaxis)[3,4,5]			
Injection: Health Care Setting	$150.50	N/A	GAF

[1] HCPCS Codes G0008, G0009, G0010.
[2] https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonalantibodies.
[3] https://www.cms.gov/monoclonal.
[4] Beneficiary coinsurance and deductible are not applicable.
[5] As of the issuance of the CY2023 PFS NPRM, this product is only available under EUA as injection.

Medical Necessity and Documentation Requirements for Nonemergency, Scheduled, Repetitive Ambulance Services (section III.I) (Page 1,016)

CMS is seeking public comment on proposed language that clarifies documentation and medical necessity requirements for nonemergency, scheduled, repetitive ambulance services, by modifying § 410.40(e)(2)(ii).

Medicare Provider and Supplier Enrollment and Conditions of DMEPOS Payment (section III.J) (Page 1,024)

In comparison to most other provider and supplier types, DMEPOS suppliers have long presented to the Medicare program an elevated risk of fraud, waste, and abuse.

CMS proposes to add a new condition of payment in paragraph (b)(6) in § 424.57. Said condition would state that in order to receive payment for a furnished DMEPOS item, the supplier must have been in compliance with all conditions of payment in 424.57(b) as well as with § 424.57(c)(1)(ii)(A) at the time the item or service was provided.

State Options for Implementing Medicaid Provider Enrollment Affiliation Provision (section III.K) (Page 1,044)

CMS is proposing to revise § 455.107(b)(1)(ii) to read that a State may, in consultation with CMS, change its selection under § 455.107(b) (after it has been made) from § 455.107(b)(2)(ii) to § 455.107(b)(2)(i). However, CMS would not permit a change from § 455.107(b)(2)(i) to § 455.107(b)(2)(ii).

Requirement for Electronic Prescribing for Controlled Substances (EPCS) for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan (section III.L) (Page 1,048)

CMS is proposing to change the year from which Prescription Drug Event (PDE) data is used from the

continued

preceding year to the current evaluated year when CMS determines whether a prescriber qualifies for an exception based on the number of Part D controlled substance claims.

Medicare Ground Ambulance Data Collection System (GADCS) (section III.M) (Page 1,060)

CMS is proposing the following changes and clarifications to the Medicare Ground Ambulance Data Collection Instrument. CMS says the changes and clarifications aim to reduce burden on respondents, improve data quality, or both. CMS has grouped its proposed changes and clarifications into four broad categories:

- Editorial changes for clarity and consistency.
- Updates to reflect the web-based system.
- Clarifications responding to feedback from questions from interested parties and testing.
- Typos and Technical Corrections

A draft of the updated instrument that includes all of the CY 2023 proposed changes to review and provide comments on is posted on the CMS website at: https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html.

Proposal to Revise HCPCS Level II Coding Procedures for Wound Care Management Products (section III.N) (Page 1,084)

CMS is proposing: (1) that the assignment of A codes to all wound care management products (that are not regulated by FDA as drugs or biological products that would otherwise be eligible for separate payment under section 1847A of the Act) would continue with respect to products for which a HCPCS Level II code is requested for the first time, as well as for wound care management products to which CMS previously assigned a Q code; (2) to discontinue all existing Q codes for wound care management products; (3) to, prior to the assignment of an A code, require products with an existing Q code that were described by the applicant as a 361 HCT/P to submit a HCPCS Level II re-application within 12 months of the effective date of the final rule (that is, January 1, 2024); (4) to require a recommendation letter from the FDA's TRG to be submitted as part of the HCPCS Level II application for all wound care management products described by the applicant as a 361 HCT/P, regardless if it is a first time application or re-application for a product with an existing Q code; and (5) to evaluate HCPCS Level II coding applications for all 361 HCT/P wound care management products through our biannual coding cycles for non-drugs and non-biological products, rather than on a quarterly basis, beginning January 1, 2024.

III. UPDATES TO THE QUALITY PAYMENT PROGRAM (Page 1,099)

The following material is from CMS' quality fact sheet. The material is quoted.

Policy Area	Proposal
	General
MVP Development	We're proposing to broaden the opportunities for the public to provide feedback on viable [MIPS Value Pathways] MVP candidates by posting draft versions of MVP candidates on the [Quality Payment Program] QPP website to solicit feedback for a 30- day period. We would review all feedback and determine if any recommended changes should be incorporated into a candidate MVP before it's proposed in rulemaking. We wouldn't consult with the group or organization that submitted the original MVP candidate in advance of rulemaking. We're also 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. For example, an MVP on surgical and post-operative care may include the involvement of clinician types such as nurse practitioners and physician assistants.

continued

Policy Area	Proposal
MVP Maintenance	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 CY 2022 PFS Final Rule we finalized the process to submit recommended changes to previously finalized MVPs by sending an email to CMS detailing the recommended changes for the MVP, by performance category. We're proposing 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.
MVP Participation Options	As finalized in the CY 2022 PFS Final Rule, for the 2023, 2024, and 2025 MIPS performance years, we define an MVP Participant as a: Individual clinician Single specialty group Multispecialty group* Subgroup Alternative Payment Models (APM) Entity
	* Beginning in the 2026 performance year, multispecialty groups will be required to form subgroups in order to report MVPs. In the CY 2022 PFS NPRM, we proposed, but didn't finalize, to use the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) as the data source for specialty determination of single specialty and multi-specialty groups. After additional analysis and in consideration of comments received, we're proposing to revise the definitions of single specialty and multispecialty groups to identify Medicare Part B claims as the data source for determining specialty type. Specifically, we're proposing to 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.
Proposed & Modified MVPS	
MVPs	We're proposing 5 new MVPs and revising the 7 previously established MVPs that would be available beginning with the 2023 performance year. The 5 new proposed MVPs for the 2023 performance year are: Advancing Cancer Care Optimal Care for Kidney Health Optimal Care for Patients with Episodic Neurological Conditions Supportive Care for Neurodegenerative Conditions Promoting Wellness Modifications to 7 previously established MVPs: Advancing Care for Heart Disease MVP – we're proposing to expand the coverage of the MVP by including measures for subspecialists such as electrophysiology, heart failure, and interventionalists. This proposal includes the addition of 6 quality measures and 2 improvement activities, and the removal of 2 improvement activities. We're also proposing to add the ONC Direct Review attestation requirement that was inadvertently omitted from the Promoting Interoperability performance category in the CY 2022 PFS Final Rule. Optimizing Chronic Disease Management MVP – we're proposing to include another patient survey measure, Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS, to offer additional patient survey measure choices. We're also proposing to add the ONC Direct Review attestation requirement that was inadvertently omitted from the Promoting Interoperability performance category in the CY 2022 PFS Final Rule. Advancing Rheumatology Patient Care – we're proposing to remove 2 improvement activities (based on updates to the improvement activities inventory and redundancy with quality measures in the MVP) and to add one quality measure and one improvement activity. We're also proposing to add the ONC Direct Review attestation requirement that was inadvertently omitted from the Promoting Interoperability performance category in the CY 2022 PFS Final Rule. Improving Care for Lower Extremity Joint Repair – we're proposing to remove one improvement activity based on updates to the improvement activities inventory and to add one improvement activity. We're also proposing to add the ONC Direct Review attestation requirement that was inadvertently omitted from the Promoting Interoperability performance category in the CY 2022 PFS Final Rule. Adopting Best Practices and Promoting Patient Safety within Emergency Medicine – we're proposing to remove 2 improvement activities based on updates to the improvement activities inventory and to add one improvement activity. We're also proposing to add the ONC Direct Review attestation requirement that was inadvertently omitted from the Promoting Interoperability performance category in the CY 2022 PFS Final Rule. Patient Safety and Support of Positive Experiences with Anesthesia – we're proposing to remove one improvement activity based on updates to the improvement activities inventory and to add one improvement activity. We're also proposing to add the ONC Direct Review attestation requirement that was inadvertently omitted from the Promoting Interoperability performance category in the CY 2022 PFS Final Rule. Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes – we're proposing to add the ONC Direct Review attestation requirement that was inadvertently omitted from the Promoting Interoperability performance category in the CY 2022 PFS Final Rule.

continued

Policy Area	Proposal
	Subgroups
Subgroup Registration	We 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). We're proposing to add a 3rd required element to the subgroup registration: A description of the composition of the subgroup, which may be selected from a list or described in a narrative. We're also proposing that a clinician (identified by National Provider Identifier (NPI)) would only be allowed to register for one subgroup per Taxpayer Identification Number (TIN). We're not proposing any other criteria limiting the composition of subgroups. We'd like to encourage flexibility for groups to explore different ways clinicians may form subgroups and support team-based care delivery. *Please refer to Appendix A for more information about previously finalized policies, including MVP registration requirements.
Subgroup Eligibility	We're proposing to 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 Scoring	For measures calculated through administrative claims, we're proposing to calculate and score these measures at the TIN level (of the affiliate group), not at the subgroup level:
	Foundational Layer (MVP Agnostic): We're proposing for each selected population health measure in an MVP, subgroups would be assigned the affiliated group's score, if available. In instances where a group score is not available, each such measure is excluded from the subgroup's final score.
	Quality Performance Category: We're proposing for each selected outcomes-based administrative claims measure in an MVP, subgroups would be assigned the affiliated group's score, if available. In instances where a group score is not available, each such measure will be assigned a zero score.
	Cost Performance Category: We're proposing that subgroups would be assigned the affiliated group's cost score, if available for the cost performance category in an MVP. In instances where a group score is not available, each such measure is excluded from the subgroup's final score.
Subgroup Final Score	We're proposing to not assign a score for a subgroup that registers but doesn't submit data as a subgroup.

CMS is also issuing a number of Requests for Information (RFIs) to solicit feedback on the future of the QPP.

Payment Gap for QPs and Subsequent Transition to Enhanced Conversion Factor Updates RFI: We're requesting information from interested parties about what, if anything, they would like to see CMS do in response to the transition from having a 5.0 percent lump sum APM Incentive Payment awarded to Qualifying APM Participants (QPs) in payment years 2019-2024 to having a 0.75 percent Conversion Factor update available to them in payment years 2026 onward. (There is no APM incentive authorized under MACRA for the 2023 performance year/2025 payment year.)

MIPS Quality Performance Category Health Equity RFI: We included a MIPS health equity RFI on the development and implementation of health equity measures for the quality performance category as we seek to enhance and increase the number of measures in future years that address and/or incorporate factors pertaining to health equity. To further align policies specific to health equity and health disparities across programs, the Medicare Shared Savings Program also included an RFI regarding health equity in the proposed rule.

Developing Quality Measures that Address Amputation Avoidance in Diabetic Patients RFI: We believe amputation avoidance in diabetic patients is a priority clinical topic, particularly in the measurement of underserved

continued

populations, as there are substantial equity concerns related to racial disparity in diabetes-related amputation. We seek input from stakeholders on identifying measure concepts on this topic that would lead to improved patient outcomes and proactive care in an attempt to avoid amputation.

QCDRs/QRs/Health IT Vendors Supporting all Measures in MVPs RFI: In response to comments, questions and concerns from third party intermediaries, we're seeking feedback on whether third party intermediaries (e.g., Qualified Clinical Data Registries (QCDRs)) should have the flexibility to choose which measures they will support within the MVP and why through an RFI.

CME Organizations Submitting Improvement Activities for MVPs RFI: We're seeking feedback on allowing Continuing Medical Education (CME) Organizations to directly submit improvement activities for MVPs; this would require the creation of a new type of third-party intermediary. We're seeking feedback on the value of implementing policies to approve CME Organizations or accreditation entities as third-party intermediaries, including whether accreditation entities serving as third party intermediaries could reduce clinician reporting burden.

Advancing the Trusted Exchange Framework and Common Agreement (TEFCA) RFI: We're requesting input on CMS' opportunities to incentivize participation in TEFCA through programs that incentivize high quality care, or through program features in value-based payment models that encourage certain activities that can improve care delivery. We're also interested in a potential role for TEFCA in payment and operations activities, such as submission of clinical documentation to support claims adjudication and prior authorization processes.

Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in the Quality Payment Program RFI: We're building upon the FHIR RFI included in the CY 2022 PFS proposed rule to continue our engagement with interested parties on the topic of CMS' aim to move to digital quality measurement in the CY 2023 PFS proposed rule. We want to continue engaging with interested parties on the topics of (a) data standardization activities related to leveraging and advancing standards for digital data, and (b) approaches to transition to FHIR electronic clinical quality measure (eCQM) reporting, as initial steps in our transition to digital quality measurement.

Potential Transition to Individual QP Determination RFI: We are requesting information from interested parties on a change in the way we make QP determinations, which would move to the individual level rather than the current APM Entity level. Our focus includes how we can best encourage specialists in Advanced APMs to participate in performance measurement.

V. Regulatory Impact Analysis (Page 1,423)

Do not overlook the regulatory impact analysis section. It contains much additional and helpful information

Appendices (Page 1,642)

Appendix 1 MIPS Quality Measures
TABLE Group A: New Quality Measures Proposed for the CY 2023 Performance Period/2025 MIPS Payment Year and Future Years (Page 1,642)

TABLE Group B: Previously Finalized Specialty Measures Sets Proposed for Combination and Proposed Modifications to Previously Finalized Specialty Measures Sets for the CY 2023 Performance

continued

Period/2025 MIPS Payment Year and Future Years (Page 1,656)

TABLE Group C: Previously Finalized Quality Measures Proposed for Removal in the CY 2023 Performance Period/2025 MIPS Payment Year and Future Years (Page 1,911)

TABLE Group CC: Proposed Partial Removal of 2 Previously Finalized Quality Measures as Component Measures in Traditional MIPS and Proposed Retention of These 2 Measures for Use in Relevant MVPs for the CY 2023 Performance Period/2025 MIPS Payment Year and Future Years (Page 1,921)

TABLE Group D: Previously Finalized Quality Measures with Substantive Changes Proposed for the CY 2023 Performance Period/2025 MIPS Payment Year and Future Years (Page 1,922)

TABLE Group DD: Previously Finalized Quality Measures with Substantive Changes Proposed for Partial Removal as Component Measures in Traditional MIPS and Proposed for Retention for Use in Relevant MVPs for the CY 2023 Performance Period/2025 MIPS Payment Year and Future Years (Page 2,009)

TABLE Group E: Previously Finalized Web Interface Quality Measures with Substantive Changes Proposed for the CY 2023 Performance Period and Future Years (Page 2,013)

Appendix 2: Improvement Activities

Table A: Proposed New Improvement Activities for the CY 2023 Performance Period/CY 2025 MIPS Payment Year and for Future Years (Page 2,022)

TABLE B: Proposed Changes to Previously Adopted Improvement Activities for the CY 2023 Performance Period/CY 2025 MIPS Payment Year and for Future Years (Page 2,027)

TABLE C: Improvement Activities Proposed for Removal for the CY 2023 Performance Period/CY 2025 MIPS Payment Year and for Future Years (Page 2,032)

Appendix 3: MVP Inventory

This appendix contains two groups of proposed MVP tables: Group A, proposed new MVPs and Group B, proposed modifications to previously finalized MVPs. Group A includes five new proposed MVPs. Group B includes seven previously finalized MVPs with proposed modifications. (Page 2,035)

Group A: New MVPs Proposed for the CY 2023 Performance Period/2025 MIPS Payment Year and Future Years (Page 2,037)

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

Group B: Modifications to Previously Finalized MVPs for the CY 2023 Performance Period/2025 MIPS Payment Year and Future Years (Page 2,052)

B.1: Advancing Care for Heart Disease MVP
B.2: Optimizing Chronic Disease Management MVP
B.3: Advancing Rheumatology Patient Care MVP
B.4: Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP
B.5: Improving Care for Lower Extremity Joint Repair MVP
B.6: Patient Safety and Support of Positive Experiences with Anesthesia MVP
B.7: Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP

continued

FINAL THOUGHTS

This is one of the most difficult rules to navigate. There is simply too much old, unnecessary and redundant history. CMS needs to concentrate on the changes being proposed. Second, there is simply no excuse for not providing a detailed table of contents.

CMS tells us their goal is to reduce burden. A good start would be revamping the entire preamble section to remove the clutter of past history. Most of us are not interested in what happened 5, 10 or even 40 years, ago. These rules should not be a history lesson.

As noted previously, there are sections of this rule that have not been addressed.

The actual changes to the reg text extends some 100+ pages. (Page 1,536)

It is understandable why commenters/ stakeholders and others say the quality material is both burdensome and confusing. From our perspective, it is difficult to comprehend that CMS recognizes this fact, acknowledges the issues, and says it is reducing such. With the proposed quality material (250 pages) the related Appendix data (425 pages) the physician quality system appears out-of-control. CMS admits it will take many more years to achieve its ambitious results.

With constant changes and revisions, the basic question remains. Is CMS achieving any quality changes or just collecting statistics?

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting