AMERICA'S PHYSICIAN GROUPS

Key Impacts of the 2023 Final Rules: Medicare Physician Fee Schedule, Shared Savings Program, and Outpatient Prospective Payment System

November 2022

Housekeeping

- Type questions in the Q & A box
- This webinar will be recorded
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AMERICA'S PHYSICIAN GROUPS

Who We Are

- 335 physician organizations
- 170,000 physicians that serve 90 million patients
- Capitation / Delegation is the destination
- “Taking Responsibility for America’s Health”

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America's Physician Groups (APG)

Our Three Pillars

Education

- Regional meetings
- Deep dives
- Coalitions for ACOs, MA, & Medicaid

Leadership

- CMS, CMMI, members of Congress
- Community leaders
- Bridging between other associations

Advocacy

- Representation on Capitol Hill
- Federal comment letters
- Washington Weekly Update

Mission Statement

The mission of America's Physician Groups is to assist accountable physician groups to improve the quality and value of healthcare provided to patients. America's Physician Groups represents and supports physician groups that assume responsibility for clinically integrated, comprehensive, and coordinated healthcare on behalf of our patients. ***Simply, we are taking responsibility for America's health.***

Strategic Vision

America's Physician Groups and its member groups will continue to drive the evolution and transformation of healthcare delivery throughout the nation.

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Speaker

Jennifer Podulka serves as the Vice President of Federal Policy for APG.

Prior to joining APG, Jennifer advised Congress on payment and policy options for traditional Medicare and Medicare Advantage as a staff member for the *Medicare Payment Advisory Commission (MedPAC)* and the *Government Accountability Office*.

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Agenda

- Medicare Physician Fee Schedule (PFS)
- Medicare Shared Savings Program (MSSP)
- MSSP Quality Changes
- Quality Payment Program (QPP)
- Outpatient Prospective Payment System (OPPS)

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Overview

The 3304-page PFS & MPPS and 1764-page OPPS & ASC final rules were released on November 1

APG's top-line summary: Focus was on **extensive changes to MSSP designed to increase participation**

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Medicare Physician Fee Schedule (MPFS)

Physician Payment Updates

The Conversion factor for 2023 is $33.06

This is a **decrease** in the conversion factor of 4.5% from 2022 to 2023 due to the expiration of the 3% payment increase passed last year and changes to E/M codes

The total impact on payment rates is potentially much larger due to continuation of sequester (2%) and the PAYGO (4%)

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Evaluation and Management (E/M) Visits

- Changes in coding and documentation for Other E/M visits approved by the AMA CPT Editorial Panel
- The revised coding and documentation framework include CPT code definition changes such as:
  - New descriptor times (where relevant)
  - Revised interpretive guidelines for levels of medical decision making
  - Choice of medical decision making or time to select code level (except for a few families like ED visits and cognitive impairment assessment, which are not timed services)
- The elimination of the use of history and exam to determine code level
  - Replaced with a requirement for a medically appropriate history and exam

Split (or Shared) Visit Changes

2023

Substantive portion = choice of:

- History
- Performing a physical exam
- Making a medical decision
- Spending more than half of total time

2024

Substantive portion = more than half of total time

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Telehealth Policies Expiration Dates

PHE + 151 days

Telehealth services that don't fit 1 of 3 CMS criteria, per **Consolidated Appropriations Act of 2022**

CMS included 38 services + instructions for others soon

End of 2023

Category 3 = services that CMS plans to keep testing on a temporary basis

CMS added 54 new services

Permanent

CMS reviews **Category 1 & 2** services and adds them to a list of approved telehealth services through rulemaking

CMS added 5 new services

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Telehealth Policies Expiration Dates

PHE + 151 days

Telehealth services that don't fit 1 of 3 CMS criteria, per **Consolidated Appropriations Act of 2022**

CMS included 38 services + instructions for others soon

HCPCS	Short Descriptor
77427	Radiation tx management x5
92002	Eye exam new patient
92004	Eye exam new patient
93750	Interrogation vad in person
94002	Vent mgmt inpat init day
94003	Vent mgmt inpat subq day
94004	Vent mgmt nf per day
94664	Evaluate pt use of inhaler
96125	Cognitive test by hc pro
99218	Initial observation care
99219	Initial observation care
99220	Initial observation care
99221	Initial hospital care
99222	Initial hospital care
99223	Initial hospital care
99234	Observ/hosp same date
99235	Observ/hosp same date
99236	Observ/hosp same date
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init

HCPCS	Short Descriptor
99324	Domicil/r-home visit new pat (deleted from the PFS for CY 2023)
99325	Domicil/r-home visit new pat (deleted from the PFS for CY 2023)
99326	Domicil/r-home visit new pat (deleted from the PFS for CY 2023)
99327	Domicil/r-home visit new pat (deleted from the PFS for CY 2023)
99328	Domicil/r-home visit new pat (deleted from the PFS for CY 2023)
99341	Home visit new patient
99342	Home visit new patient
99343	Home visit new patient (deleted from the PFS for CY 2023)
99344	Home visit new patient
99345	Home visit new patient
99441	Phone e/m phys/qhp 5-10 min
99442	Phone e/m phys/qhp 11-20 min
99443	Phone e/m phys/qhp 21-30 min
99468	Neonate crit care initial
99471	Ped critical care initial
99475	Ped crit care age 2-5 init
99477	Init day hosp neonate care

Telehealth Policies Expiration Dates

PHE + 151 days

Telehealth services that don't fit 1 of 3 CMS criteria, per **Consolidated Appropriations Act of 2022**

CMS included 38 services + instructions for others soon

CMS will provide more guidance on statutorily required flexibilities, including:

- Patients can access telehealth regardless of location, including from home
- Certain services can be provided audio-only
- PTs, OTs, speech-language pathologists, and audiologists can provide telehealth services
- FQHCs and RHCs can provide telehealth services, and these are paid using average PFS rates
- The delay in the 6-month in-person requirement for mental health services

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Telehealth Policies Expiration Dates

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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
92565	Stenger test pure tone
92567	Tympanometry
92568	Acoustic refl threshold tst
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

HCPCS	Short Descriptor
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
97530	Therapeutic activities
97537	Community/work reintegration
97542	Wheelchair mngment training
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

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Telehealth Policies Expiration Dates

End of 2023

Category 3 = services that CMS plans to keep testing on a temporary basis

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CMS finalized changes to how telehealth should be billed:

- Continue to bill with modifier “95” along with the POS code corresponding to where the service would have been furnished in-person through the later of the end of the year the PHE ends or 2023
- When a facility is the originating site, POS 02 may be used and the facility fee can be billed, beginning the 152nd day after the end of the PHE
- CPT modifier “93” can be appended to claim lines, as appropriate, for services furnished using audio-only communications
- All providers, including RHCs, FQHCs, and OTPs must append Medicare modifier “FQ” (*Medicare telehealth service was furnished using audio-only communication technology*) for allowable audio-only services furnished in those settings

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Telehealth Policies Expiration Dates

End of 2023

Category 3 = services that CMS plans to keep testing on a temporary basis

CMS added 54 new services

CMS finalized rule for how telehealth interacts with direct supervision requirements that will go into effect *after the end of the calendar year the PHE ends*:

- Medicare telehealth services can no longer be performed by clinical staff incident to the professional services of the billing physician or practitioner who directly supervises the service through their virtual presence

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Telehealth Policies Expiration Dates

Permanent

CMS reviews **Category 1 & 2** services and adds them to a list of approved telehealth services through rulemaking

CMS added 5 new services

HCPCS	Short Descriptor
G0316	Prolonged inpatient or observation services by physician or other QHP
G0317	Prolonged nursing facility services by physician or other QHP
G0318	Prolonged home or residence services by physician or other QHP
G3002	Chronic pain tx monthly b
G3003	Addition 15m pain mang

Behavioral Health Services Workforce

- Currently, Medicare covers licensed professional counselor (LPCs) and licensed marriage and family therapists (LMFTs) and similar professionals as auxiliary personnel under the direct supervision of a physician or other clinician
- CMS is switching from requiring direct to general supervision

Medicare Shared Savings Program (MSSP)

CMS Made MSSP More Attractive

Allowed advanced investment payments (AIP) to eligible, low-revenue ACOs that are new to the MSSP and inexperienced with Medicare ACOs

The quality score may be modified based on health equity adjustment

Slower transition to risk-based pathway for ACOs inexperienced with performance-based risk

Modified benchmarking methodology to reduce the impact of ratchet effect and negative regional adjustment

Advanced Incentive Payments (AIP)

Up front payment of $250,000 and per beneficiary quarterly payments over 2 years, capped at 10,000 beneficiaries. Recouped if shared savings is achieved.

The quarterly payment amount based on whether the beneficiary is 1) enrolled in Medicare Part D LIS or 2) dually eligible or 3) lives in an area with high ADI

Limited to low revenue and inexperienced ACOs that apply for BASIC path

ACOs must submit plans describing how the AIP will be spent to build care coordination capabilities and address specific health disparities

Risk factor score:	**1-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75-84**	**85-100**
Quarterly per beneficiary payment amount	$0	$20	$24	$28	$32	$36	$40	$45

Transitions to Risk-Based Pathway

- Current “Pathways to Success” Program – Basic (A-E) and Enhanced Track. Each year progress to next risk level
- Current Track A or B (one-sided risk) ACOs can remain in current track until agreement ends
- In 2024, inexperienced ACOs can opt for one-sided risk for up to 7 years; once experienced, automatically move to Track E
- All ACOs can opt to remain in BASIC Track E and never advance to ENHANCED Track
- Low revenue ACOs with expenditures below the benchmark but not above the minimal savings rate would receive a prorated savings of 20% to 25% depending on the level

ACO Benchmarking

- Historical benchmarks have been updated using a blend of national and regional growth rates
- CMS will add new Accountable Care Prospective Trend (ACPT) for agreement periods beginning January 1, 2024
- The ACPT will be prospectively set at the outset of an agreement period and remain unchanged
- The new blend will be $^{1}/_{3}$ new ACPT and $^{2}/_{3}$ existing national + regional
- Guardrail: if an ACO generates losses, CMS will re-calculate using the old 2-way blend

ACO Benchmarking

Currently, ACOs' benchmarks are reset at the start of each agreement period

CMS will incorporate an adjustment in historical benchmarks for prior savings, for agreement periods starting January 1, 2024 and later

Currently, historical benchmarks get a regional adjustment with a ±5% cap

CMS will cap negative regional adjustments at -1.5%, then decrease negative regional adjustments as share of dual eligibles or HCC scores increase, for agreement periods starting January 1, 2024 and later

CMS will switch from current 3% risk score cap to first account for risk changes from BY3 to PY then apply 3% cap

Medicare Shared Savings Program (MSSP)

Quality Changes

2022 MSSP Quality

For 2022 — 2024	For 2022 — 2023	Beginning 2024	Beginning 2025
ACOs can report ***either*** the 10 CMS Web Interface measures ***or*** the 3 eCQMs/MIPS CQMs.	ACOs eligible for shared savings if they achieve at least the 30th percentile across all category scores	ACOs eligible for shared savings if they achieve at least the 40th percentile across all category scores	ACOs will be required to report the 3 eCQMs/MIPS CQMs
ACOs that report both will receive the higher score of the two.	ACOs that report the 3 eCQMs/MIPS CQMs have flexibility in meeting this threshold	ACOs that report the 3 eCQMs/MIPS CQMs have flexibility in meeting this threshold ← **Just added**	

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2023 MSSP Quality Changes

A health equity adjustment (10 bonus points) on quality score for high performance on 3 all-payer eCQM/MIPS with higher proportions of underserved beneficiaries

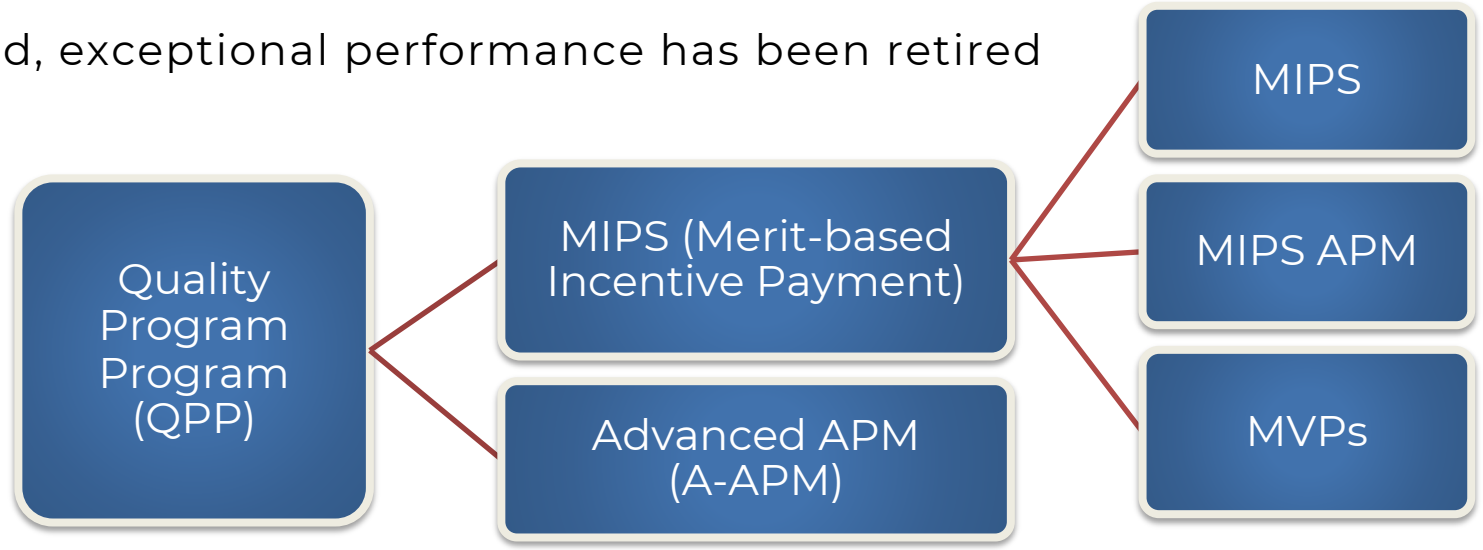
Sliding scale of savings if ACO is equal or higher than 10th percentile on at least 1 of 4 outcome measures.

Also, sliding scale of losses for ENHANCED Track ACO with same criteria. The shared loss rate could range from 40% to 75%.

Quality Payment Program (QPP)

QPP Overview

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula for clinician payment and established the Quality Payment Program (QPP)
- 2023 is Year 7 of QPP – Year 1 (3 points), Year 2 (15 points), Year 3 (30 points), Year 4 (45 points), Year 5 (60 in 2021), Year 6 (75 in 2022), Year 7 (75 in 2023) is baseline threshold
- Performance Year is 2 years from Payment year –
  2023 Performance Year goes with 2025 Payment Year
- In 2023 performance period, exceptional performance has been retired



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Different Payments Under MIPS and A-APMs

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Qualifying APM Participant (QP)

Patient Count Threshold

Payment Year 2025 Moves to 50%

Payment Year	2020	2021		2022 (2020 Performance Yr)		2023		2024	
QP Payment Threshold	20%	35%	20%	35%	20%	35%	20%	35%	20%
	Medicare	Total	Medicare*	Total	Medicare*	Total	Medicare*	Total	Medicare*

* Minimal Needed From Medicare FFS

APG Advocacy Priority

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Qualifying APM Participant (QP)

Payment Amount Threshold

Payment Year 2025 Moves to 75%

Payment Year	2020	2021		2022 (2020 Performance Yr)		2023		2024	
QP Payment Threshold	25%	50%	25%	50%	25%	50%	25%	50%	25%
	Medicare	Total	Medicare*	Total	Medicare*	Total	Medicare*	Total	Medicare*

* Minimal Needed From Medicare FFS

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New 2023 QPP Policies

- **MIPS**
  - 200 → 198 measures
  - Health equity-related measures added to high priority measures
  - Data completeness remains at 70% for 2023, increases to 75% for 2024 and 2025
  - The Prescription Drug Monitoring Program (PDMP) measure optional → required
  - Continuing to use the mean final performance score (75 points) from the 2017 performance year as the performance threshold for the 2023 performance year
- **A-APMs**
  - 8% minimum on the Generally Applicable Nominal Risk standard made permanent

Outpatient Prospective Payment System (OPPS)

New 2023 OPPS and ASC Policies

Payment rates for OPPS and ASC increase by 3.8%

Rural Emergency Hospitals (REHs) become new Medicare provider type

Telehealth for behavioral health services covered for hospital outpatient, audio-only permitted

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What to Watch For

- Any agency action on telehealth through regular notice and comment rulemaking. Will Congress act on telehealth flexibilities?
- CMS will release more detailed guidance on new MSSP features. Application cycle for 2024 will kick-off in late spring.
- Will Congress extend the 5% Advance APM bonus?
- Rural emergency hospitals get underway

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Q&A

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Best Practices

- Text should be 28 or 32 point size, with titles being 36 to 44 point size. Anything below 24 points is not easily readable.
- Use high-contrasting colors for your design template. Blue and black fonts are easiest to read. Avoid using red or orange except to bring attention to an item (red circle around a word). Use no more than three colors on your slides.

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Best Practices

- A rule of thumb on how much text to put in a slide is the 1-6-6 rule. One idea per slide, no more than six bullets and no more than six words per bullet. In practice, less content is usually better.
- Do not overemphasize text with multiple formats, for example, using all caps and underline in in one heading. Try to stay with a common font that will be clearly visible on the laptop at the event.

Best Practices

- Using images, illustrations or charts to get your point across helps break up the monotony when there are a lot of text slides. Make sure that the images are large enough to see.
- If you have a video or your presentation requires Internet access, it is essential that you let APG staff know as far in advance as possible.

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Restate Learning Objectives

- What have we reviewed today?
- Should line up with first slide on Learning Objectives

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