Summary of 2023 Changes to the Medicare Physician Fee Schedule, Quality Payment Program, and Other Federal Programs Proposed Rule

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Updates to the Physician Fee Schedule

Introduction

On July 7, 2022, the Centers for Medicare & Medicaid Services (CMS) published the Proposed Rule for the Medicare Physician Fee Schedule (PFS) and the Quality Payment Program (QPP) for Calendar Year (CY) 2023. The Proposed Rule updates payment rates and policies for services supplied under the PFS on or after January 1, 2023. You may access the CMS press release for more information and links to relevant fact sheets. As used throughout this document, “proposed” refers to matters which are scheduled to be implemented in the 2023 payment year but could change following review and comment by the public. This should be compared to “finalized” which refers to matters that will go into effect in 2023 and are not currently subject to review and change.

Regulatory Impact Analysis

Conversion Factor

For CY23, the proposed conversion factor is $33.08 (rounded), representing a decrease of $1.53 (or roughly 4.5 percent), as compared to the CY22 conversion factor of $34.61. This decrease is a result of budget neutrality adjustments, as required by law, as well as the required statutory update to the conversion factor for CY23 of zero percent and the expiration of the three percent increase to physician payments for CY22. The zero percent update is due to CMS’ federal obligation to implement a zero percent conversion factor in FY23 and ensure payment rates for individual services do not significantly impact estimated Medicare spending. The expiration of the three percent increase was mandated by the Protecting Medicare and American Farmers from Sequester Cuts Act and was an attempt from Congress to temporarily boost physician reimbursement to mitigate the impact of pandemic-related expenses.

Below details the calculation of the CY23 conversion factor. Table 138 of the CY23 PFS proposed rule shows the payment impact of the policies contained in the proposed rule on PFS services, inclusive of the proposed impact to Internal Medicine physicians and its subspecialties. For the CY23 rulemaking cycle, the Agency has provided an additional impact table, Table 139, that includes a facility/non-facility breakout of payment changes. , that includes a facility/non-facility breakout of payment changes.

<table>
<thead>
<tr>
<th>TABLE 1: Calculation of the CY 2023 PFS Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY 2022 Conversion Factor</td>
</tr>
<tr>
<td>Conversion Factor without CY 2022 Protecting Medicare and American Farmers from Sequester Cuts Act</td>
</tr>
<tr>
<td>Statutory Update Factor</td>
</tr>
<tr>
<td>CY 2023 RVU Budget Neutrality Adjustment</td>
</tr>
<tr>
<td>CY 2023 Conversion Factor</td>
</tr>
</tbody>
</table>

Clinical Labor Pricing Update

As discussed in the College’s CY 2022 summary of the PFS final rule, in CY19, CMS updated the supply and equipment prices used for practice expense (PE) as part of a market-based pricing transition; CY22 was the final year of this four-year transition. At that time, however, the Agency did not propose to update the clinical labor pricing. Clinical labor rates were last updated for CY02. In our CY22 comments
to the Agency, ACP raised concerns that the long delay created a significant disparity between CMS’ clinical wage data and the market average for clinical labor. As a result, for CY22, the Agency finalized a multi-year transition to update the clinical labor pricing to maintain relativity with the recent supply and equipment pricing updates, thereby promoting payment stability from year-to-year. An example of the transition from the current to fully implemented new pricing is provided below. For CY23, the Agency is requesting feedback on the continued update to clinical labor pricing, as well as any data that will improve the accuracy of the final pricing.

### TABLE 2: Example of Clinical Labor Pricing Transition

<table>
<thead>
<tr>
<th>Current Price</th>
<th>$1.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final Price</td>
<td>$2.00</td>
</tr>
<tr>
<td>Year 1 (CY 2022) Price</td>
<td>$1.25</td>
</tr>
<tr>
<td>Year 2 (CY 2023) Price</td>
<td>$1.50</td>
</tr>
<tr>
<td>Year 3 (CY 2024) Price</td>
<td>$1.75</td>
</tr>
<tr>
<td>Final (CY 2025) Price</td>
<td>$2.00</td>
</tr>
</tbody>
</table>

#### Strategies for Updates to Practice Expense Data Collection and Methodology

The PE inputs used in settings PFS rates, including both the development of PE RVUs and, historically, the relative shares among work, PE, and malpractice RVUs across the PFS, are central in developing accurate rates and maintaining appropriate relativity among PFS services and overall payment among the professionals and suppliers paid under the PFS. However, unlike other payment systems with cost reporting systems, PFS data inputs are primarily based on exogenous proprietary data, namely historical survey data, that is over a decade old. Each year, CMS continues to improve accuracy, predictability, and sustainability of updates to the PE valuation methodology. For CY23, the Agency is issuing a comment solicitation to better understand how to improve the collection of PE data inputs and refine the PE methodology. As discussed, last year CMS implemented a final transition year for supply and equipment pricing updates and started the first year of a four-year phase-in update to the clinical labor rates. However, the indirect PE data inputs remain tied to legacy information that is decades old.

To build on this progress, the Agency now believes indirect PE would also benefit from a refresh that implements similar standard and routine updates. Particularly, the Agency believes routine refreshes would reduce the likelihood of unpredictable shifts in payment, especially when such shifts could be driven by the age of data available rather than comprehensive information about changes in actual costs. Of the various PE data inputs, CMS believes that indirect PE data inputs, which reflect costs such as office rent, IT costs, and other non-clinical expenses, present the opportunity to build consistency, transparency, and predictability. As part of this effort, the Agency has contracted with the RAND Corporation to develop and assess potential improvements in the current methodology used to allocate indirect practice costs in determining PE RVUs for a service, model alternative methodologies for determining PE RVUs, and identify and assess alternative data sources that CMS could use to regularly update indirect practice cost estimates.

In the CY23 PFS proposed rule, CMS is signaling its intent to move to a standardized and routine approach to valuation of indirect PE. The Agency welcomes input on topics related, but not limited to, the following:
• Potential approaches to design, revision, and fielding of a PE survey that fosters transparency;
• Mechanisms to ensure that data collection and response sampling adequately represent physicians and non-physician practitioners across various practice ownership types, specialties, geographies, and affiliations;
• Alternatives that would result in more predictable results, increased efficiencies, and reduced burdens;
• Methods to adjust PE to avoid the unintended effects of undervaluing cognitive services due to low indirect PE; and
• Whether the Agency should stagger updates year-to-year for each update or establish “milestone” years at regular intervals during which all direct PE inputs would be updated in the same year.

Notably, the Agency additionally identified that market consolidation, shifts in workforce alignment, and the evolution of types of business entities predominant in health care markets all suggest significant transformation in the composition and proportions of PE required to furnish care. CMS states that ideally, PE data inputs and calculation methodology would better account for indirect/overhead costs, current trends in the delivery of health care, the use of machine learning technology and EHRs, and the cost differentials in independent versus facility-based practices. For these reasons, the Agency is seeking comment on current and evolving trends in health care business arrangements, use of technology, or similar topics that might affect or factor into indirect PE calculations.

Potentially Misvalued Services under the Physician Fee Schedule, and Valuation of Specific Codes

**Immunization Administration (CPT Codes 90460, 90461, 90471, 90472, 90473, and 90474)**

For CY23, CMS proposes the RUC-recommended work RVU for all six codes in the Immunization Administration family. Inclusive of minor refinements, the Agency also proposes the RUC’s recommended direct PE inputs for these services. In the proposed rule, CMS notes its intent to seek additional information that specifically identifies the resource costs and inputs that should be considered to establish payment for these vaccine administration services on a long-term basis. This request for comment is consistent with CMS’ policy objectives for ensuring maximum access to immunization services.

**Code Descriptor Changes for Annual Alcohol Misuse and Annual Depression Screenings (HCPCS Codes G0442 and G0444)**

Over the past several years, the College has requested that CMS revise the code descriptors for HCPCS codes G0442 and G0444 to state “up to 15 minutes”, allowing physicians to efficiently furnish the service. As currently described, claims for the service are denied where records suggest that a full 15 minutes was not reached. In the CY23 PFS proposed rule, the Agency notes its belief that these screenings may not require a full 15 minutes to perform, so CMS is proposing to revise the descriptor to establish a lower time limit for both codes. Therefore, the proposed modification would read: HCPCS code G0442, “Annual alcohol misuse screening, 5 to 15 minutes”, and for HCPCS code G0444, “Annual depression screening, 5 to 15 minutes.”

**Chronic Pain Management and Treatment Bundles (HCPCS GYYY1 and GYYY2)**
In the CY22 PFS final rule, CMS discussed potential new policies for physicians treating patients with chronic pain. In this year’s proposed rule, the Agency is proposing a new monthly bundled payment for management of patients with chronic pain, identified as codes GYYY1 and GYYY2. GYYY1 is defined as:

*Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care (e.g. physical therapy and occupational therapy, and community based care), as appropriate. Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (When using GYYY1, 30 minutes must be met or exceeded.)*

GYYY2 would apply to up to three units of an additional 15 minutes of chronic pain management per month. The Agency is proposing to define “chronic pain” as pain lasting more than three months. CMS is also proposing to value GYYY1 and GYYY2 based on a crosswalk to the principal care management codes 99424 and 99425, respectively.

**Behavioral Health Services**

In an effort to improve access to behavioral health services, CMS is proposing to allow licensed professional counselors, marriage and family therapists, and other types of behavioral health practitioners to provide behavioral health services under general (rather than direct) supervision. The Agency is also proposing to create a new behavioral health integration service category, allowing payment for clinical psychologists and licensed clinical social workers who provide integrated behavioral health services as part of a patient’s primary care team.

**Evaluation and Management (E/M) Visits, including Valuation and Split (or Shared) Visits**

**E/M Visits, General Updates**

CMS is proposing to adopt most of the CPT- and RUC-recommended changes to several E/M code families, including hospital inpatient; hospital observation visits; consultations; and services in the emergency department, nursing facility, home, and residence. These proposals are part of the ongoing updates to E/M visits, like those finalized in the CY21 PFS final rule for office/outpatient E/M visit coding and documentation. Effective January 1, 2023, the revised coding and documentation framework is intended to reduce administrative burden and would include CPT code definition changes, including:

- New descriptor times (where relevant);
- Revised interpretative guidelines for levels of medical decision making;
- Choice of medical decision making or time to select code level; and
- Eliminated use of history and exam to determine code level (instead, there would be a requirement for a medically appropriate history and exam).
The Agency is proposing to maintain the current billing policies that apply to E/M services while it considers potential revisions that might be necessary in future rulemaking. CMS is also proposing to create Medicare-specific coding for payment of other E/M prolonged services, like what CMS adopted in CY23 for payment of office/outpatient prolonged services.

**Hospital Inpatient and Observation Care (CPT Codes 99221-99236)**

The Agency is proposing to adopt the revised CPT codes 99221-99223 and 99231-99236. It is important to note that the CPT descriptors for these codes specify that, when selecting the code level based on time, the indicated increment must be “met or exceeded.” CMS is also proposing to adopt the CPT instruction that “per day” means the “calendar date”.

To inform these revisions, the hospital inpatient or observation care codes were surveyed via the RUC process, with the College as a participant, for the January 2022 RUC meeting. The times captured the total time on the date of the encounter by calendar date. The Agency is proposing to accept the RUC recommendations for work RVUs and times for the CPT codes below. There are no PE inputs for these codes.

**TABLE 3: Proposed Valuation of Hospital Inpatient or Observation Care Services**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Work RVUs</th>
<th>Intra-service Time</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221</td>
<td>1.63</td>
<td>40 minutes</td>
<td>40 minutes</td>
</tr>
<tr>
<td>99222</td>
<td>2.60</td>
<td>55 minutes</td>
<td>55 minutes</td>
</tr>
<tr>
<td>99223</td>
<td>3.50</td>
<td>74 minutes</td>
<td>74 minutes</td>
</tr>
<tr>
<td>99231</td>
<td>1.00</td>
<td>25 minutes</td>
<td>25 minutes</td>
</tr>
<tr>
<td>99232</td>
<td>1.59</td>
<td>36 minutes</td>
<td>36 minutes</td>
</tr>
<tr>
<td>99233</td>
<td>2.40</td>
<td>52 minutes</td>
<td>52 minutes</td>
</tr>
<tr>
<td>99234</td>
<td>2.00</td>
<td>45 minutes</td>
<td>50 minutes</td>
</tr>
<tr>
<td>99235</td>
<td>3.24</td>
<td>68 minutes</td>
<td>76 minutes</td>
</tr>
<tr>
<td>99236</td>
<td>4.30</td>
<td>85 minutes</td>
<td>97 minutes</td>
</tr>
</tbody>
</table>

**Hospital and Observation Discharge Day Management (CPT Codes 99217, 99238, and 99239)**

Effective January 1, 2023, the CPT Editorial Panel deleted the observation discharge code, CPT code 99217 (*Observation care discharge day management*) and revised both hospital discharge day management codes, CPT codes 99238 (*Hospital inpatient or observation discharge day management; 30 minutes or less*) and CPT code 99239 (*more than 30 minutes*), so that CPT codes 99238 and 99239 may be billable for discharge of hospital inpatient or observation patients. In the CY23 PFS proposed rule, the Agency is proposing to adopt the revised CPT codes 99238 and 99239. CMS also notes its proposal to not allow for additional payment of prolonged services to be reported with CPT codes 99238 and 99239.

The revised discharge day management codes, CPT codes 99238 and 99239, were also surveyed for the January 2022 RUC meeting, with the College as a participating society. CMS is proposing to accept the RUC recommendations for CPT codes 99238 (work RVU 1.50, intra-service time 28 minutes, total time 38 minutes) and 99239 (work RVU 2.15, intra-service time 45 minutes, 64 minutes total time). The Agency is additionally proposing to accept the RUC-recommended direct PE inputs for CPT codes 99238 and 99239 without refinement.
Cognitive Assessment and Care Planning (CPT Code 99483)

In February 2021, the CPT Editorial Panel revised CPT code 99483 to replace “50 minutes” from its descriptor with a revised time value determined by the RUC survey to align with the principles underlying the office/outpatient E/M CPT codes. For 2023, the descriptor time will be 60 minutes typical time instead of 50 minutes. Due to the increase in the valuation for office/outpatient E/M visits, CMS finalized in 2021 an increase to the value, from 3.44 to 3.80 work RVUs. In the CY23 PFS proposed rule, the Agency is deciding not to propose the RUC-recommended work RVU of 3.50 because it believes this service is appropriately valued more highly than the analogous office/outpatient E/M visit code, CPT code 99205. In the interest of supporting access to this service, CMS is instead proposing an increase from the current 3.80 to 3.84 to account for the increase in physician time with use of a total time ratio.

Valuation of Prolonged Inpatient or Observation E/M Services (HCPCS Codes GXXX1, GXXX2, and GXXX3)

At the outset of its proposals, the Agency states that it does not agree that there is inherently greater complexity of patient need or intensity of work for E/M visits furnished in non-office settings (e.g., inpatient, emergency department, and home settings) compared to the office settings. Therefore, CMS is proposing it is more accurate to make payment based on the same time increment of physician work in these various settings. To accomplish this, CMS is proposing that the three-pronged prolonged codes (HCPCS G codes GXXX1-GXXX3) be valued identically across settings, based on the RUC-recommended value for CPT code 99417 (work RVU 0.61 with a crosswalk to 99417). The Agency is also proposing direct PE inputs for these three codes that are identical to RUC-recommended PE inputs for CPT code 99417. The table below summarizes the proposed rules for reporting inpatient or observation E/M prolonged services by physicians. Additional detail and descriptors can be found in a forthcoming section entitled “Proposed New G Codes to Replace Existing Prolonged Services CPT Codes”.

### TABLE 4: Proposed Time Thresholds to Report Inpatient or Observation E/M Prolonged Services

<table>
<thead>
<tr>
<th>Primary E/M Service</th>
<th>Prolonged Code*</th>
<th>Time Threshold to Report Prolonged</th>
<th>Count Physician Time Spent Within This Time Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial IP/Obs. Visit (99223)</td>
<td>GXXX1</td>
<td>105 minutes</td>
<td>Date of visit</td>
</tr>
<tr>
<td>Subsequent IP/Obs. Visit (99223)</td>
<td>GXXX1</td>
<td>80 minutes</td>
<td>Date of visit</td>
</tr>
<tr>
<td>IP/Obs. Same-Day Admission/Discharge (99236)</td>
<td>GXXX1</td>
<td>125 minutes</td>
<td>Date of visit to 3 days after</td>
</tr>
<tr>
<td>IP/Obs. Discharge Day Management (99238-9)</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Emergency Department Visits</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Initial NF Visit (99306)</td>
<td>GXXX2</td>
<td>95 minutes</td>
<td>1 day before visit + date of visit + 3 days after</td>
</tr>
<tr>
<td>Subsequent NF Visit (99310)</td>
<td>GXXX2</td>
<td>85 minutes</td>
<td>1 day before visit + date of visit + 3 days after</td>
</tr>
<tr>
<td>Service Description</td>
<td>Code</td>
<td>Time</td>
<td>Reference Date</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>------</td>
<td>--------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>NF Discharge Day Management</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Home/Residence Visit New Pt (99345)</td>
<td>GXXX3</td>
<td>141 minutes</td>
<td>3 days before visit + date of visit + 7 days after</td>
</tr>
<tr>
<td>Home/Residence Visit Estab. Pt. (99350)</td>
<td>GXXX3</td>
<td>112 minutes</td>
<td>3 days before visit + date of visit + 7 days after</td>
</tr>
<tr>
<td>Cognitive Assessment and Care Planning</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Consults</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

*Time must be used to select visit level. Prolonged service time could be reported when furnished on any date within the primary visit’s surveyed timeframe and would include time with or without direct patient contact by the physician.

**Split (or Shared) Visits**

For CY23, CMS is proposing to delay the split (or shared) visits policy finalized in CY22 for the definition of *substantive portion* until January 1, 2024. Rather than the substantive portion being defined as more than half of the total time, the substantive portion of a visit may be met by any of the following elements:

1. History;
2. Performing a physical exam;
3. Medical decision making; or
4. Spending more than half of the total time.

The Agency notes that this delay is a direct result of ongoing concerns from the College and other stakeholders that relate to practice patterns, as well as possible adjustments needed to the practice’s internal processes or information systems to track visits based on time, rather than MDM. Although proposing a delay in the transition, CMS continues to believe it is appropriate to define the substantive portion of a split (or shared) service as more than half of the total time. This proposal, however, is intended to allow for the changes in the coding and payment policies for inpatient or observation E/M visits to take effect for CY23 and allows for a one-year transition for physicians and other practitioners to get accustomed to the new changes and adopt their workflow in practice.

**Rebasing and Revising the Medicare Economic Index**

CMS is proposing to revise and rebase the Medicare Economic Index (MEI), which consists of an index that measures market price changes of inputs used to provide physician services. The current MEI is primarily based on data from 2006, which has created challenges since the MEI is utilized to proportion the components of the RBRVS between work, practice expense, and professional liability insurance (PLI). CMS completed its most recent calibration for CY14 RVUs when the MEI was last updated.

For CY23, the Agency proposes a new methodology for estimating base year expenses that relies on publicly available data from the U.S. Census Bureau NAICS 6211 (Office of Physicians), which would allow for the use of data that are more reflective of current market conditions of physician ownership practices, rather than only reflect costs for self-employed physicians. CMS proposes to use the 2017 data for the proposed 2017-based MEI (see table below), because the Agency believes it is the most recently available and complete data due to concerns about the COVID-19 pandemic’s impact on more
recent data. To supplement the data, the Agency is proposing to use several data sources for further disaggregation of compensation costs and all other residual costs, including:

- The 2017 Bureau of Labor Statistics (BLS) Occupational Employment and Wage Statistics (OEWS);
- The 2012 Bureau of Economic Analysis (BEA) Benchmark Input-Output data (I/O);
- The 2006 AMA PPIS; and
- The 2020 AMA Physician Practice Benchmark Survey.

<table>
<thead>
<tr>
<th>TABLE 5: Current and Proposed Proportions of Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>RVU Component</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Physician Work</td>
</tr>
<tr>
<td>Practice Expense</td>
</tr>
<tr>
<td>Malpractice or PLI</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

CMS estimates that proposed weights would not impact overall spending but would significantly impact the PE geographic practice cost index (GPCI). Therefore, in an effort to promote predictability in payments, the Agency proposes not to use the rebased and revised MEI weights for the PE GPCI in CY23 and solicits comment on potential implementation timing for future rulemaking. Specifically, CMS proposes to maintain current use of 2006-based MEI cost share weights for CY23 GPCIs.

**Geographic Practice Cost Indices**

In the CY23 PFS proposed rule, CMS is proposing new GPCIs (see Table 19), along with a geographic adjustment factor (GAF) for each (see Addenda D and E). Half of the proposed GPCI adjustments would be phased-in starting in CY23, with the remaining half in CY24. The proposed GPCIs reflect the 1.0 work GPCI floor, which was extended through 2023 by the Consolidated Appropriations Act. CMS notes that the proposed rebasing of the MEI cost weight methodology would not impact calculation of 2023 GPCIs.

CMS also proposes to consolidate the number of unique fee schedule areas in California, underscoring that the changes would not have any payment implications. The Agency additionally proposes technical changes to improve the accuracy of the GPCI methodology, including making changes to occupation codes and groups, and calculating each locality’s GAF based on CY20 Medicare utilization data, rather than the 2006-based MEI cost share weights (Table 22). Lastly, CMS noted that in response to calls from the College and other stakeholders, the Agency has evaluated eight possible alternative data sources for calculating the physician office rent component of the PE GPCI, but all failed on at least one key criterion. Therefore, the Agency will continue to use American Community Survey data.

**Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)**

Over several years, CMS has been engaged in the examination of coordinated and collaborative care services in professional settings. This engagement has led CMS to the conclusion that care coordination included in services, such as office visits, do not always adequately describe the non-face-to-face care management work involved in primary care.
In this proposed rule there are new codes proposed to describe Chronic Pain Management (CPM) and general Behavioral Health Integration (BHI) services, describing general BHI services performed by clinical psychologists (CPs) and clinical social workers (CSWs). The proposed CPM codes would be created to separately pay for a specified set of pain management and treatment services, specifically including the administration of validated rating scales, and a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes.

In an effort to be consistent with the new services that are being proposed for practitioners billing under the PFS, CMS is proposing to include CPM services in the general care management code G0511 when these services are provided by RHCs and FQHCs, with no proposed change to the average used to calculate the G0511 payment rate.

In addition, CPs and CSWs are considered practitioners that can provide services in RHCs and FQHCs; in this proposed rule, CMS is clarifying that when CPs and CSWs provide the services described in code GBHI1 in an RHC or FQHC, they can bill HCPCS code G0511. If finalized as proposed, RHCs and FQHCs that furnish the new CPM and GBHI services performed by CPs and CSWs would be able to bill these services using 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.

For RHCs and FQHCs, in-person visits will not be required until the 152\textsuperscript{nd} day after the end of the PHE for COVID-19.

**Strategies for Improving Global Surgical Package Valuation**

As part of its ongoing efforts to address challenges regarding the surgical global periods, the Agency is seeking public comment on strategies to improve the accuracy of payment for the global surgical packages under the PFS. Global packages generally include the surgical procedure and any services typically provided during the pre- and post-operative periods, including E/M services and hospital discharge services. There are three types of global packages: 0-day, 10-day, and 90-day. Additional detail about how global packages are billed and what activities are included may be found here. While the concept of global payment for some procedures has been included in the PFS since its inception, in the past decade, CMS has engaged with interested parties regarding numerous concerns about the accuracy and validity of the valuation of the global packages. Particular attention has also been paid to the E/M visits included.

To address these concerns, the Agency has requested public feedback and the College has provided information to help support more accurate valuations. As background, in the CY13 PFS proposed rule, the Agency discussed two reports released by the HHS Office of the Inspector General in 2005 and 2012. The findings were that practitioners were performing fewer E/M post-operative visits than had been included in the valuation for these global packages, suggesting that Medicare was paying for care that was not actually being delivered. In the CY15 PFS proposed rule, CMS discussed the barriers to accurate valuation of global packages and noted several other issues in connection with the global packages, including concerns about PE values associated with follow-up visits in the physician’s office. To improve the accuracy of valuation and payment for the various components of global packages, the Agency then finalized a policy to transform all 10-day and 90-day global codes to 0-day global codes in 2018.

Implementation of this policy, however, was impeded by Section 523(a) of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, which prohibits the Secretary of HHS from implementing the
policy and requires CMS to collect data to value surgical services. In the CY17 proposed rule, CMS proposed a three-pronged approach to collect timely and accurate data on the frequency and inputs involved in furnishing global services.

In 2019, the RAND Corporation issued two reports based on its analysis of the data collected. Notably, RAND’s analysis found that the reported number of E/M visits matched the expected number for only four percent of reviewed 10-day global packages and 38 percent of reviewed 90-day global packages. Based on these analyses, RAND released a third report that analyzed the current valuation of global packages based on the difference between the number of post-operative E/M visits observed and the expected number of such E/M visits. The report also provided hypothetical valuations for the global packages based on these adjustments of the work RVUs, physician time, and direct PE inputs. In the CY20 PFS final rule, the Agency shared these reports and received public comment, with some parties challenging the methodology or conclusions and others being supportive of the efforts.

While some parties challenged the RAND report, in this year’s PFS proposed rule, the Agency has supported the report, asserting that there is no indication suggesting that post-operative E/M visits are being performed more frequently than indicated. CMS continues to be concerned that its current valuations of the global packages reflect certain E/M visits that are not typically furnished in the global period, and thus, are not occurring. To inform the ongoing assessment, the Agency is welcoming any comments on ideas for other sources of data that would help assess global package valuation. In the CY23 PFS proposed rule, CMS is seeking public comment on:

- Whether the post-operative health care landscape has changed in ways that impact the relevance of the global packages;
- Whether changes to health care delivery, including changes in care coordination and use of medical technology, have impacted the number and level of post-operative E/M visits needed to provide effective follow-up care to patients, the timing of when post-operative care is being provided, and who is providing the follow-up care;
- The hypothesis that some beneficiaries are not receiving the number of post-operative visits that were contemplated;
- Whether, or how, recent changes in the coding and valuation of separately billable E/M services may have impacted global packages;
- Whether global packages, particularly 10-day and 90-day periods, continue to serve a purpose when physicians could otherwise bill separately not only for the post-operative E/M visits, but also for aspects of post-operative care management furnished for some patients;
- The perceived misalignment between the E/M visits included in global packages and separately billable E/M services; and
- The RAND methodology and the specific alternative to request the RUC make recommendations on new values.

Regarding possible strategies for a revaluation process, the Agency has proposed various approaches, such as:

1. Revaluing all 10- and 90-day global packages at one time;
2. Revaluing only the 10-day global packages, because these appear to have the lowest rates of post-operative visits performed;
3. Revaluing 10-day global packages and some 90-day global packages; or
4. Relying on the RUC’s Potentially Misvalued Code process to identify and revalue misvalued
global packages over the course of many years.

Medicare Parts A and B Payment for Dental Services

Currently, the traditional Medicare program (also known as Medicare Fee-for-Service) covers a limited
set of dental services. In this proposed rule, CMS is proposing to clarify and codify certain aspects of the
current Medicare program payment policies for dental services. The Agency is also proposing and
seeking comment on payment for other dental services that are substantially related and integral to the
clinical success of an otherwise covered medical service.

Telehealth

Telephone E/M Services, and Requests to Add Services to the Medicare Telehealth Services List

In the CY21 PFS final rule, CMS temporarily added several services to the Medicare Telehealth Services
List using the Category 3 criterion. To determine whether a service should be available on a Category 3
basis, the Agency assessed whether these services can, outside of the circumstances of the PHE, be
furnished using the full scope of service elements via two-way, audio-video communication technology,
without jeopardizing patient safety or quality of care. Services are added on a Category 3 basis when the
services were temporarily included on the Medicare Telehealth Services List during the PHE and it is
found that there is likely to be clinical benefit when furnished via telehealth, but there is not yet
sufficient evidence available to consider the services for permanent addition under the Category 1 or
Category 2 criteria.

In the CY23 PFS proposed rule, CMS is proposing to add additional services to the Medicare Telehealth
Services List on a Category 3 basis. It is important to note, however, that CMS is not proposing to change
the length of time the services that are temporarily included will remain on the List; the services
temporarily included on a Category 3 basis will continue to be included through the end of CY23. The
Agency has noted in the event that the PHE extends well into CY23, it may consider revising this policy.
Additionally, the Consolidated Appropriations Act, 2022 (CAA, 2022) amended Section 1834(m) of the
Social Security Act to extend a number of flexibilities that are in place during the COVID-19 PHE for 151
days after the end of the PHE. To align the availability of these services with those flexibilities, the
Agency is proposing to continue to allow certain telehealth services that would otherwise not be
available via telehealth after the expiration of the PHE to remain on the Medicare Telehealth Services
List for 151 days after the expiration of the PHE.

Table 7 of the CY23 PFS proposed rule includes the full list of Medicare Telehealth Services List requests;
Table 8 lists the services that the Agency is proposing for addition to the Medicare Telehealth Services
List on a Category 3 basis. Notably, CMS considered the addition of the telephone E/M codes, 99441-
99443. However, the Agency is proposing that the telephone E/M services will not remain on the
Medicare Telehealth Services List after the end of the PHE and the 151-day post-PHE extension period.
CMS reasoned that, outside of the circumstances of the PHE, the telephone E/M services would not be
analogous to in-person care, nor would they be a substitute for a face-to-face encounter. Accordingly,
CMS is proposing to remove these services after that period and will assign these codes a “bundled”
status after the end of the PHE and the 151-day extension period and will post the RUC-recommended
RVUs for these codes in accordance with its usual practice. Following the end of the PHE and the 151-
day extension period, CMS stated that two-way, audio-video communications technology will continue to be the appropriate standard that will apply for Medicare telehealth services. CMS considered the addition of the telephone E/M codes, 99441-99443. However, the Agency is proposing that the telephone E/M services will not remain on the Medicare Telehealth Services List after the end of the PHE and the 151-day post-PHE extension period. CMS reasoned that, outside of the circumstances of the PHE, the telephone E/M services would not be analogous to in-person care, nor would they be a substitute for a face-to-face encounter. Accordingly, CMS is proposing to remove these services after that period and will assign these codes a “bundled” status after the end of the PHE and the 151-day extension period and will post the RUC-recommended RVUs for these codes in accordance with its usual practice. Following the end of the PHE and the 151-day extension period, CMS stated that two-way, audio-video communications technology will continue to be the appropriate standard that will apply for Medicare telehealth services.

As part of its implementation of the CAA, 2022, CMS is extending certain flexibilities in place during the PHE for 151 days after the PHE ends. As noted, this includes allowing certain services to be furnished via audio-only. The Agency is also proposing that telehealth claims will require the appropriate place of service (POS) indicator to be included on the claim, rather than modifier -95, after a period of 151 days following the end of the PHE and that modifier -93 will be available to indicate that a Medicare telehealth service was furnished via audio-only technology, where appropriate. Additional detail can be found in a forthcoming section entitled “Use of Modifiers for Medicare Telehealth Services Following the End of the PHE for COVID-19”.

Emotional/Behavior Assessment, Psychological, or Neuropsychological Testing and Evaluation Services

CMS received several requests to add emotional/behavior, psychological, or neuropsychological testing and evaluation services, including those described by CPT codes 97151-97158, to the Medicare Telehealth Services List permanently on a Category 2 basis. These services are currently on the Medicare Telehealth Services List temporarily for the duration of the PHE. In considering this request, the Agency is proposing to include these services for temporary inclusion on a Category 3 basis. These services were not originally included on a Category 3 basis after the initial assessment, but CMS noted there is likely to be a clinical benefit when furnished via telehealth, so they meet the criteria for temporary inclusion. While the Agency is not electing to permanently include these services on a Category 1 or Category 2 basis, due to concerns that this patient population may not be able to be fully assessed via interactive audio-video technology, the Agency is soliciting comment on this determination and its patient safety concerns.

Proposed New G Codes to Replace Existing Prolonged Services CPT Codes

As discussed, the Agency is proposing to create three new HCPCS codes: GXXX1, GXXX2, and GXXX3. These services are defined below and will describe prolonged services associated with certain types of E/M services. GXXX1-GXXX3 are proposed to replace existing codes that described prolonged services, specifically inpatient prolonged services CPT codes 99356 and 99357, also described below. CMS believes that these proposed HCPCS G codes would be sufficiently similar to psychiatric diagnostic procedures or office/outpatient visits currently on the Medicare Telehealth Services List to qualify for inclusion on the list on a Category 1 basis. Therefore, the Agency is proposing to add HCPCS codes GXXX1-GXXX3 to the Medicare Telehealth Services List on a Category 1 basis. Table 9 of the CY23 PFS
proposed rule lists the services the Agency is proposing for permanent addition to the Medicare Telehealth Services List on a Category 1 basis.

GXXX1 (Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (Do not report GXXX1 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 993X0.) (Do not report GXXX1 for any time unit less than 15 minutes.)

GXXX2 (Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99306, 99310 for nursing facility evaluation and management services). (Do not report GXXX2 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 993X0.) (Do not report GXXX2 for any time unit less than 15 minutes.)

GXXX3 (Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99345, 99350 for home or residence evaluation and management services). (Do not report GXXX3 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99417.) (Do not report GXXX3 for any time unit less than 15 minutes.)

99356 (Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient or observation Evaluation and Management service)).

99357 (Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)).

Services Proposed for Removal from the Medicare Telehealth Services List after 151 Days Following the End of the PHE

As discussed in the CY22 PFS final rule, at the conclusion of the PHE, the associated waivers and interim policies will expire, payment for Medicare telehealth services will once again be limited by the requirements of Section 1834(m) of the Act, and the Agency will return to the policies established through regular notice-and-comment rulemaking. Services that have been added to the Medicare Telehealth Services List on a Category 3 basis will remain on the list through the end of CY23. Under its current policy, all other services that were temporarily added to the List on an interim basis and have not been added to the List on a Category 1, 2, or 3 basis will not remain on the list after the end of the PHE.

The CAA, 2022, extends some of the flexibilities for an additional 151 days after the end of the PHE, including the policy that the originating site for the telehealth service can be any site in the United
States (U.S.) at which the beneficiary is located when the service is furnished, including the beneficiary’s home. To give full effect to this provision, 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 (i.e., those not currently added to the list on a Category 1, 2, or 3 basis) for an additional 151 days after the PHE ends. Table 10 of the CY23 PFS proposed rule includes a list of those services that are temporarily available for the PHE, which the Agency is proposing to retain on the List for an additional 151 days following the end of the PHE. As discussed, the telephone E/M codes, 99441-99443, are proposed to be removed once that period ends. On the 152nd day, payment for Medicare telehealth services will once again be limited by the requirements of Section 1834(m) of the Act and claims for these codes will be denied.

Use of Modifiers for Medicare Telehealth Services Following the End of the PHE for COVID-19

Prior to CY17, Medicare telehealth services furnished via interactive, audio-video telecommunications systems were reported using the GT modifier. In the CY17 PFS final rule, the Agency finalized creation of a new POS code for Medicare telehealth, POS “02”. As a result of the COVID-19 pandemic, CMS instructed physicians to report the POS code that would have been reported had the service been furnished in person. For the duration of the PHE, CMS finalized the use of the CPT telehealth modifier, modifier “95”, to be applied to claims that describe services furnished via telehealth.

In the CY23 PFS proposed rule, the Agency is proposing that Medicare telehealth services furnished on or before the 151st day after the end of the PHE will continue to be processed for payment when accompanied with modifier “95”. CMS further proposes that physicians can continue to report the POS code that would have been reported had the service been furnished in-person during the 151-day period after the end of the PHE. However, Medicare telehealth services performed with dates of service occurring on or after the 152nd day will revert to pre-PHE rules and will no longer require modifier “95” to be appended to the claim, but the appropriate POS indicator will need to be included. For Medicare telehealth services furnished on or after the 152nd day after the end of the PHE, the Agency is proposing the POS indicators as follows:

- POS “02”, which is proposed to be redefined as Telehealth Provided Other than in Patient’s Home (Descriptor: The location where health services and health related services are provided or received, 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).

Once the 151-day period ends, the Agency is proposing that payment for using either of the telehealth POS codes be made at the PFS facility payment rate. CMS is also proposing to align those telehealth services described as taking place in the beneficiary’s home, using POS “10” for Medicare telehealth, and those services not provided in a patient’s home, using POS “02” for Medicare telehealth, to be made at the same facility payment amount. In support of these proposals, CMS notes its belief that the facility payment amount best reflects the PE, both direct and indirect, involved in furnishing services via telehealth.
The Agency further proposes that, beginning January 1, 2023, a physician billing for telehealth services furnished using audio-only communications technology shall append CPT modifier “93” (Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System: Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction) to Medicare telehealth claims. As discussed previously, this proposal will only apply to those services for which the use of audio-only technology is permitted. Currently, modifier “93” may also be applied to Medicare telehealth mental health services and those telehealth services for the treatment of a substance use disorder or a co-occurring mental health disorder when the originating site is the beneficiary’s home.

Expiration of PHE Flexibilities for Direct Supervision Requirements

CMS is not proposing to make the temporary exception to allow immediate availability for direct supervision through virtual presence permanent, but the Agency continues to seek information on whether the flexibility to meet the immediate availability requirement for direct supervision through the use of real-time, audio/video technology should potentially be made permanent. CMS seeks comment regarding the possibility of permanently allowing immediate availability for direct supervision through virtual presence using real-time, audio/video technology for only a subset of services, acknowledging that it may be inappropriate to allow direct supervision without physical presence for some services due to potential concerns over patient safety. Based on gaps in the currently available evidence, CMS is in need of more information as they consider whether to make permanent a temporary exception to their direct supervision policy.

Originating Site/Implementation of 2021 and 2022 CAAs

CMS proposes to implement provisions of the 2021 and 2022 CAAs that: (1) allow a patient's home as an originating site for mental health telehealth services (diagnosis, evaluation, or treatment) furnished on or after the end of the COVID-19 PHE; (2) establish a six-month in-person requirement for mental health telehealth services (i.e., no payment for telehealth services furnished in a patient’s home unless the physician furnishes the item or service in-person, without the use of telehealth, within six months prior to the first time the physician furnishes a telehealth service to the beneficiary, and thereafter, as deemed appropriate by the HHS Secretary); and (3) extend coverage and payment for telehealth services on the List as of March 15, 2022, furnished via audio-only for 151 days after the end of the COVID-19 PHE. This applies only to telehealth services on the List that are designated as eligible to be furnished via audio-only technology as of March 15, 2022, and includes behavioral health, counseling, and educational services.

CMS will soon be issuing instructions or other sub-regulatory guidance to effectuate other amendments of the CAA, 2022, including provisions that: (1) temporarily allow any site in the U.S. where a beneficiary is located at the time of the telehealth service, including the individual’s home, as an originating site for 151 days after the end of the COVID-19 PHE (including for mental health telehealth services and for individuals with a substance use disorder diagnosis for purposes of treatment); (2) temporarily continue
payment for telehealth services furnished by FQHCs and RHCs for 151 days after the end of the COVID-19 PHE; and (3) delay the in-person requirement for mental health telehealth services (in-person visit with physician within six months prior to the initial mental health telehealth service), including mental health visits furnished by RHCs and FQHCs, for 151 days after the end of COVID-19 PHE. Thus, the in-person requirements for mental health telehealth services and mental health visits furnished by RHCs and FQHCs will be effective on the 152nd day after the end of the COVID-19 PHE.

Clinical Laboratory Fee Schedule: Revised Data Reporting Period, Phase-in of Payment Reductions, Laboratory Specimen Collection, and Travel Allowance

CMS proposes six key changes in the 2023 PFS proposed rule.

- The PFS proposes to change PAMA reporting timelines and requirements in response to recent shuffling in price data reporting schedules;
- CMS wants to change the part of the PAMA regulations requiring phase-in of payment cuts to indicate that the payment for CY 2022 may not be reduced by more than zero percent, as compared to CY 2020, and that 15 percent will be the maximum payment cut for CYs 2023 through 2025;
- CMS is proposing to “codify and clarify various laboratory specimen collection fee policies” included in the Medicare Claims Processing Publication;
- CMS wants to create new regulations governing the calculation of travel allowances for specimen collection;
- CMS is proposing to reduce the minimum age payment limitation for certain colorectal cancer screening to 45 years and add coverage of follow-on screening after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result; and
- By eliminating the COVID-19 pandemic payment bump of FY 2022, CMS is proposing a three percent cut in PFS payments for 2023.

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) furnished by Opioid Treatment Programs (OTPs) Services

Methadone Pricing

In CY21, Medicare paid $37.38 for methadone provided via Opioid Treatment Program during an episode of care. In CY22, the Average Sale Price for oral methadone was 50 percent of the CY21 price and CMS reported difficulty gathering accurate and representative methadone pricing data. This led CMS to freeze the payment rate at the CY21 level for CY22 for codes G2067 and G2078 and solicit comments on utilization and other topics. Commenters expressed support for maintaining the CY21 rates due to increased demand during the pandemic and ongoing opioid overdose crisis. Some noted that the rates do not reflect the actual costs of administering oral methadone.

For CY23, CMS proposes to base the payment amount for the drug component of HCPCS codes G2067 and G2078 for CY23 and subsequent years on the payment amount for methadone in CY21. The Agency proposes to update this amount annually to account for inflation using the PPI for Pharmaceuticals for Human Use (Prescription). This would result in an inflation-adjusted payment of $39.29 in CY23.

Proposed Changes to the Rate for Individual Therapy in the Bundled Rate
The HHS OIG has found that only 16 percent of the one million Medicare beneficiaries with OUD receive medication treatment and only four percent receive treatment from an OTP, potentially indicating access to care problems. OTP representatives indicate this may be due in part to the payment rate for the individual therapy in the weekly bundle and may not reflect the actual cost of delivering care. Since patients receiving care at OTPs are in high need and require more intensive therapy services than other beneficiaries, CMS proposes to “modify the payment rate for the non-drug component of the bundled payment for an episode of care to base the rate for individual therapy on a crosswalk to CPT code 90834 (Psychotherapy, 45 minutes with patient), instead of a crosswalk to CPT code 90832 (Psychotherapy, 30 minutes with patient), as is our current policy” (Proposed Rule p. 608). The rate would be adjusted based on the MEI.

**Mobile Components Operated by OTPs**

CMS proposes to clarify that the geographic adjustment for medically reasonable and necessary OTP services provided via an OTP mobile unit will be treated as if they were delivered at a physical OTP facility. CMS believes this proposal would increase access in remote and underserved areas.

**Flexibilities for OTPs to Use Telecommunications for Initiation of Treatment with Buprenorphine**

CMS summarizes recent policy changes to facilitate access to OTP services via telecommunications, including substance use disorder counseling and therapy via two-way, audio-video communication technology and audio-only services under certain circumstances.

CMS proposes to allow OTPs to conduct intake for buprenorphine treatment via audio-video technology or audio-only if audio-video is not available to the beneficiary. CMS seeks comments on whether audio-only-based periodic assessments for buprenorphine treatment should be allowed to continue after the end of the COVID-19 PHE. The Agency also asks if this should be permitted for patients on methadone and naltrexone.

**Medicare Part B Payment for Preventive Vaccine Administration Services**

CMS is proposing two policy changes related to vaccine administration that could significantly alter the incentive structure for physician-administered vaccines. First, the Agency is proposing a shift in payments for vaccine administration based on stakeholder concerns that insufficient reimbursement is a barrier to administering routinely recommended adult vaccines. Second, CMS proposes a change to quality measures to incentivize adult vaccination and improve uptake, particularly given immunization rates declined during the COVID-19 pandemic. Both proposals could have an impact on immunization rates for clinician-administered vaccines.

**Electronic Prescribing of Controlled Substances (EPCS)**

CMS is proposing to use Prescription Drug Event (PDE) data from the evaluated year rather than the preceding year in its determination of compliance and applicability of exceptions.

With regard to the small prescriber exception, CMS is proposing to use PDE data from the current evaluated year instead of the preceding year to determine whether a prescriber qualifies for an exception based on the number of Part D controlled substances claims. If finalized, this proposal would become effective starting in CY23. Thus, for CY23 EPCS compliance, the small prescriber exception would be assessed using CY23 PDE data based on the Agency’s proposed change. Additionally, a
prescriber’s compliance status would be evaluated based on PDE data with a “Date of Service” within the evaluated calendar year, which Part D sponsors must submit by mid-way through the following year.

For example: Prescriber A had fewer than 100 Medicare Part D controlled substances prescriptions in CY22, and therefore, was excepted from EPCS compliance for CY22. During the first quarter of CY23, they issue 85 Part D controlled substance prescriptions. After Prescriber A crosses the threshold of more than 100 Part D controlled substance prescriptions, they must reach the compliance threshold of electronically prescribing at least 70 percent of all their prescribed Part D Schedule II, III, IV, and V controlled substances in CY23. If they do not utilize EPCS for at least 70 percent of Part D controlled substance prescriptions in CY 2023, including those prescribed prior to reaching the 100 Part D controlled substances prescriptions threshold, they would be subject to a compliance action based on failing to meet the EPCS requirement, unless another exception applied. PDEs with a Date of Service between January 1, 2023, to December 31, 2023, with a submission date on or before the PDE submission deadline for 2023 (that is, June 28, 2024) would be included in the compliance analysis.

CMS seeks comment on the proposal to modify the exception and on the possibility that prescribers would avoid prescribing controlled substances to Medicare beneficiaries, particularly where they are approaching the 100 Part D controlled substances prescriptions threshold late in a calendar year, in order to remain a small prescriber.

Additionally, recognizing some prescribers are expecting CMS to use the CY22 PDE to assess whether the exception applies for purposes of CY23 EPCS compliance, CMS seeks comment on an alternative for the CY23 year only. In the alternative, CMS would recognize a practitioner as a small prescriber for purposes of the exception if the prescriber had fewer than 100 Part D controlled substances prescriptions in 2022 or fewer than 100 Part D controlled substances prescriptions in 2023. CMS did not propose this option because the Agency thought it would be simpler to have a single set of exceptions for the program versus different rules for different years. Additionally, CMS believed the risk to prescribers who may change their small prescriber status would be low as the action for noncompliance for CY23 is a letter.

With regard to the recognized emergencies exception, CMS proposes to use the prescriber address from the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) to determine whether a prescriber is located in the geographic area of the government-recognized emergency or disaster for evaluating compliance or meeting an exception. It is the Agency’s intention that the EPCS exception apply to where the prescriber is located, not where the pharmacy is located, to the extent that the locations differ. CMS believes the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) would have the most current address information for prescribers who are enrolled in Medicare, and this is the data source that the QPP’s Merit-based Incentive Payment System (MIPS) uses to determine if a MIPS-eligible clinician is located in an area that has been affected by extreme and uncontrollable circumstances. Therefore, for prescribers who have an address in PECOS, CMS proposes to use the PECOS address instead of the NCPDP Pharmacy Database address to determine whether the exception is applicable. In situations where prescribers do not have a PECOS address, CMS proposes to use the prescriber address in the National Plan and Provider Enumeration System (NPPES).

CMS seeks comment on whether using NPPES, NCPDP, or some other database is appropriate when there is no prescriber address in PECOS. CMS also seeks comment on an alternative of using NPPES as the source of addresses for all prescribers. The Agency believes this data may have information for all prescribers, but that health care professionals may not update their address as often as they do in
PECOS. Finally, CMS seeks comment on other potential data sources that could be used to verify a prescriber’s address.

With regard to penalties, CMS is proposing to extend the non-compliance action of sending letters to non-compliant prescribers from CY23 to CY24. Additionally, the Proposed Rule includes a lengthy RFI for EPCS non-compliance penalties.

In the Agency’s ongoing implementation of the EPCS requirement, CMS continues to seek input to ensure they do not place too much of a burden on prescribers, as the Agency does not want this requirement to have an unintended consequence of incentivizing prescribers to stop prescribing controlled substances to Part D beneficiaries, where appropriate, should they not have EPCS setup. CMS continues to need additional time to gather more feedback from interested parties on the most effective and most appropriate type of penalties.

In this proposed rule, CMS is proposing to adjust the period of time during which the Agency will issue non-compliance letters. With respect to the period of time during which CMS noncompliance actions will consist of sending letters to prescribers that the Agency believes are violating EPCS requirements, CMS is proposing to extend the existing compliance action of sending letters to non-compliant prescribers from the CY23 EPCS program implementation year (January 1, 2023, through December 31, 2023) to the CY24 year (January 1, 2024, through December 31, 2024). If adopted, CMS compliance actions will consist of sending letters to prescribers who the Agency believes are violating the EPCS requirement between January 1, 2023, and December 31, 2024. The content of the letters would remain unchanged, continuing to consist of a notification to prescribers that they are violating the EPCS requirement, information about how they can come into compliance, the benefits of EPCS, an information solicitation as to why they are not conducting EPCS, and a link to the CMS portal to request a waiver. CMS is seeking comment on this proposal.

Request for Information re: Potential Future EPCS Penalties

CMS continues to be interested in identifying additional meaningful penalties to enforce the EPCS requirement. Therefore, CMS is seeking comment on additional penalties that the Agency may impose to enforce the EPCS requirement. Such penalties would go into effect no sooner than January 1, 2025, if CMS extends the timeframe during which they will issue non-compliance letters, as the Agency has proposed. CMS is exploring a range of options, including the following non-exhaustive list of penalties for non-compliant prescribers:

- Requiring a non-compliant prescriber to enter into a corrective action plan (CAP), which would require the non-compliant prescriber to comply with the EPCS requirement within two years prior to applying other potential actions outlined in this section.

CMS seeks comment on:

- What types of elements and actions should be in a CAP to encourage use of EPCS without being overly burdensome;
- Whether a CAP would be perceived as overly burdensome to non-compliant prescribers and whether a two-year timeframe is reasonable and appropriate; and
Whether a CAP should be applied prior to other potential actions or whether a CAP should be established in parallel with other actions.

- **Posting a non-compliant prescriber’s name on the CMS website and identifying the prescriber as non-compliant.**
  CMS seeks comment on:
  - Whether this action would sufficiently persuade prescribers to alter their behavior;
  - Whether beneficiaries and interested parties would be able to utilize this information to their benefit; and

- **Public reporting of EPCS compliance status, including that a prescriber is noncompliant, on the Care Compare website.**
  CMS seeks comment on:
  - Whether this action would sufficiently persuade prescribers to alter their behavior; and
  - Whether beneficiaries and interested parties would be able to utilize this information to their benefit.

- **Referral of non-compliant prescribers to the DEA to support potential investigations.**
  CMS seeks comment on:
  - Possibly providing a list of EPCS noncompliant prescribers to the DEA to supplement investigations;
  - Whether interested parties see this as an effective option for enforcing compliance;
  - Whether interested parties have any recommendations that increase the effectiveness of this potential option; and
  - Whether the Agency should consider the duration of EPCS non-compliance prior to referring the prescriber to the DEA and whether a CAP should be considered prior to referring the prescriber.

- **Sharing the list of EPCS non-compliant prescribers with the States.**
  CMS seeks comment on:
  - Whether interested parties believe sharing the list of EPCS non-compliant prescribers with State level entities would be beneficial to the enforcement of compliance; and
  - How States may use this information to further assist the Agency’s efforts to enforce the EPCS requirement.

- **Referral for potential fraud, waste, and abuse review.**
  CMS seeks comment on:
Whether CMS should refer Medicare enrolled prescribers who consistently do not comply with the EPCS requirement for a fraud, waste, and abuse investigation to be undertaken by CMS (e.g., after multiple years of non-compliance); and

Whether CMS should consider the duration of EPCS non-compliance when considering such a referral and whether other factors should also warrant an internal referral.

For penalties involving referral of non-compliant prescribers to the DEA and other entities, CMS' intent is to supplement the current activities of these entities rather than to create new regulatory actions. CMS envisions that information sent to these entities would be for use at the discretion of the recipient and is interested to know if interested parties believe there is any utility in referring non-compliant prescribers to the DEA, other CMS internal centers, or the States. If so, CMS seeks comment on in what manner this data can be used to supplement EPCS compliance enforcement. Any penalty involving the posting of compliance status on CMS websites would be done in a manner consistent with relevant statutory authority. For instance, CMS notes that any potential posting of compliance information on the Care Compare website would have to be done consistent with statutory authority.

The Agency believes there are multiple advantages to EPCS: improved workflow efficiencies; deterring and detecting prescription fraud and irregularities by requiring an extra layer of identity proofing; two-factor authentication and digital signature processes; providing more timely and accurate data than paper prescriptions by avoiding data entry errors and pharmacy calls to a prescriber to clarify written instructions; and enhanced patient safety through patient identity checks, safety alerts, medication menus, electronic history files, and medication recommendations that lower the risk of errors and potentially harmful interactions. CMS also acknowledged that EPCS may reduce the burden on prescribers who need to coordinate and manage paper prescriptions among staff, patients, facilities, other care sites, and pharmacies. For these and potentially other reasons, CMS believes the EPCS compliance efforts directly relate to prescriber performance and quality, and related patient experience, as contemplated by section 10331(a)(2) of the ACA. CMS is seeking comment from interested parties on these and other options they may suggest for penalties to enforce EPCS compliance. CMS is interested in public comments that address:

- Whether any penalties described above are appropriate as compliance actions without being overly burdensome;
- Whether interested parties believe these penalties will be effective at increasing prescriber compliance;
- Whether penalties should be phased in over time and, if so, after what date CMS should first impose them;
- The utility of posting compliance information to the CMS website or more specifically to the Care Compare website;
- Whether there are any other penalties not mentioned here which CMS should consider to enforce EPCS compliance; and
- How best CMS can enforce EPCS compliance by prescribers who are not billing under Medicare but who prescribe controlled substances to Medicare Part D beneficiaries.

Request for Information re: Advancing to Digital Quality Measurement and the Use of FHIR® in Physician Quality Programs
In the CY22 PFS final rule, CMS stated their aim to move fully to digital quality measurement in CMS quality reporting and value-based purchasing programs. As part of this modernization of the Agency’s quality measurement enterprise, CMS is issuing this RFI to gather additional public input on the transition to digital quality measurement. Any updates to specific program requirements related to providing data for quality measurement and reporting provisions would be addressed through future notice-and-comment rulemaking. The RFI contains five parts:

- **Background.** Provides an overview of CMS’ goals and strategies to achieve digital quality measurement and notes input and learnings relevant to these goals and strategies.
- **Potential Refined definition of Digital Quality Measures (dQMs).** Outlines potential revisions for a future definition for dQMs.
- **Data Standardization Activities to Leverage and Advance Standards for Digital Data.** Discusses data standardization strategies and potential venues for advancing data standardization.
- **Approaches to Achieve FHIR® eCQM Reporting.** Describes activities CMS is undertaking and considering to achieve FHIR-based electronic clinical quality measure (eCQM) reporting (for example, via FHIR Application Programming Interfaces or APIs) as the Agency’s initial implementation of dQMs.
- **Solicitation of Comments.** Lists all requests for input included in the RFI.

**Background**

CMS is continuing to define how the Agency can leverage existing policy to transform all CMS quality measurement to digital reporting, such as policy finalized in the Office of the National Coordinator for Health Information Technology’s (ONC) 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program final rule (Cures Act). In the CY22 PFS final rule, CMS outlined actions in four areas to transition to digital quality measures:

1. Leverage and advance standards for digital data and obtain all EHR data required for quality measures via “provider” FHIR-based application programming interfaces (APIs);
2. Redesign quality measures to be self-contained tools;
3. Better support data aggregation; and
4. Work to align measure requirements across reporting programs, other Federal programs and agencies, and the private sector where appropriate.

In this RFI, CMS focuses on data standardization activities related to leveraging and advancing standards for digital data and approaches to transition to FHIR eCQM reporting in the future, as initial steps in the Agency’s transition to digital quality measurement.

The goals of a fully digital measurement system include: reduced burden of reporting; provision of multi-dimensional data in a timely fashion, rapid feedback, and transparent reporting of quality measures; digital measures leveraged for advanced analytics to define, measure, and predict key quality issues; and quality measures that support development of a learning health system, which uses key data that are also used for care, quality improvement, public health, research, etc.

**Potential Future Definition of Digital Quality Measures (dQMs)**

In the CY22 PFS final rule, CMS suggested a potential future definition of dQM for advanced feedback. Based on comments received on the RFI that the term “software” is confusing, CMS is now further
revising their potential future definition such that a dQM is a quality measure, organized as a self-contained measure specification and code package, that uses one or more sources of health information that is captured and can be transmitted electronically via interoperable systems. CMS continues to note potential data sources for dQMs may include administrative systems, electronically submitted clinical assessment data, case management systems, EHRS, laboratory systems, prescription drug monitoring programs (PDMPs), instruments (for example, medical devices and wearable devices), patient portals or applications (for example, for collection of patient-generated data such as a home blood pressure monitor, or patient-reported health data), health information exchanges (HIEs) or registries, and other sources. CMS is currently considering how eCQMs, which use EHR data, can be refined or repackaged to fit within the potential future dQM definition. While eCQMs meet the definition for dQMs in many respects, limitations in data standards, requirements, and technology have limited their interoperability.

In the current state, there are multiple standards that must be supported (for example, Health Quality Measurement Format (HQMF) and Quality Reporting Document Architecture (QRDA)) for eCQM data collection and reporting. CMS seeks comment on this potential future refined definition of dQM and feedback on potential considerations or challenges related to non-EHR data sources.

**Data Standardization Activities to Leverage and Advance Standards for Digital Data**

As noted in the CY22 PFS final rule, CMS is considering implementing eCQM quality reporting via FHIR-based APIs based on standardized, interoperable data. CMS intends to utilize standardized data for quality measurement as a use case of digital data in a learning health system.

To advance the use of standardized data, models, implementation guides, and value sets in quality measurement, CMS continues to focus on leveraging the interoperability data requirements for standardized APIs in certified health IT authorized to specific certification criteria, set by ONC’s Cures Act final rule and any future updates made in rulemaking, as a vehicle to support modernization of CMS quality measure reporting. These API requirements are being implemented as part of a series of updates to certified health IT and include availability of data included in the USCDI via standards-based APIs. In the CY21 PFS final rule, CMS finalized that eligible clinicians and eligible hospitals, and CAHs participating in MIPS and the Medicare Promoting Interoperability Program, respectively, must transition to use of certified technology updated consistent with the 2015 Edition Cures Update by 2023. CMS aims to align with these standardized data requirements as the basis for data used in quality measurement.

CMS is directly collaborating with ONC to build requirements to support data standardization and alignment with requirements for quality measurement. ONC recently launched the USCDI+ initiative focused on supporting identification and establishment of domain specific datasets that build on the core USCDI foundation. A USCDI+ quality measurement domain currently being explored would support defining additional data specifications for quality measurement that harmonize, where possible, with other Federal agency data needs and inform supplemental standards necessary to support quality measurement.

To advance implementation of standardized data, CMS continues to collaborate with consensus standards-setting bodies such as Health Level Seven (HL7). CMS is considering how best to leverage existing implementation guides that are routinely updated and maintained by HL7 to define data standards and exchange mechanisms for FHIR-based dQMs, in a fashion that supports the learning health system and alignment across use cases, including the following existing HL7 Implementation Guides:
• US Core Implementation Guide;
• Quality Improvement Core (QI Core) Implementation Guide;
• Data Exchange for Quality Measures (DEQM) Implementation Guide; and
• Quality Measure (QM) Implementation Guide.

CMS is also considering what, if any, additional CMS-specific implementation guides may be necessary to support future digital quality measurement such as guidance on aggregation mechanisms for reporting.

CMS seeks comment on the specific Implementation Guides noted previously, additional Implementation Guides the Agency should consider, and other data and reporting components (for example, data vocabulary/terminology, alignment with other types of reporting) where standardization should be considered to advance data standardization for a learning health system.

**Approaches to Achieve FHIR(R) eCQM Reporting**

CMS previously noted in the CY22 PFS final rule the activities they are conducting to begin structuring and reporting eCQMs using FHIR; eCQMs are a subset of dQMs. CMS considers the transition to FHIR-based eCQM reporting the first step to dQM reporting, and a potential model for how future digital reporting can occur.

To support the transition, CMS continues to undertake and consider activities necessary for reporting of FHIR-based eCQMs and future dQMs. In the near term, CMS plans to: continue to convert current Quality Data Model (QDM)-based eCQMs to the FHIR standard and test the implementation of measures and submission of data elements through ongoing HL7 Connectathons; develop a unified CMS FHIR receiving system; optimize interoperable data exchange to support FHIR-based eCQM reporting; identify opportunities for the public to provide feedback on FHIR-based measure specifications prior to implementation; identify opportunities for collaboration with vendors and implementers to ensure involvement in systems development; and explore venues for continued feedback on CMS future measurement direction and data aggregation approaches.

CMS intends to continue engaging with standards development organizations to advance and maintain implementation guides to support the FHIR standard and API reporting of quality measures. CMS also continues to consider how best to leverage the ONC interoperability certification criteria related to implementing FHIR API technology to access and electronically transmit interoperable data for quality measurement. CMS continues to explore how to leverage FHIR APIs to decrease reporting burden and support implementer readiness.

CMS seeks comment on approaches to optimize data flows for quality measurement to retrieve data from EHRs via FHIR APIs, and to combine data needed for measure score calculation for measures that require aggregating data across multiple practitioners (for example, risk-adjusted outcome measures) and multiple data sources (for example, hybrid claims-EHR measures). CMS is interested in data flows that support using the same data for measurement and to provide feedback to practitioners at multiple levels of accountability, such as at the individual clinician, group, accountable care organization, and health plan levels, as these data are used for patient care and other use cases (for example, public health reporting).
CMS seeks comment on additional venues to engage with implementers during the transition to digital quality measurement and other critical considerations during the transition. CMS also seeks comment on data flow options to support FHIR-based eCQM reporting.

*Solicitation of Comments*

As noted previously, CMS seeks input on the following:

- **Refined potential future Definition of dQMs.** CMS is seeking feedback on the following as described in section IV.A.4.b. of this proposed rule:
  - The potential refined definition of digital quality measures (dQMs)?
  - Potential considerations or challenges related to non-EHR data sources?

- **Data Standardization Activities to Leverage and Advance Standards for Digital Data.** CMS is seeking feedback on the following as described in section IV.A.4.c. of this proposed rule:
  - The specific implementation guides CMS is considering, additional FHIR implementation guides CMS should consider, or other data and reporting components where standardization should be considered to advance data standardization for a learning health system?

- **Approaches to Achieve FHIR eCQM Reporting.** CMS is seeking feedback on the following (described in another section of the proposed rule):
  - Are there additional venues to engage with implementers during the transition to digital quality measurement?
  - What data flow options should CMS consider for FHIR-based eCQM reporting, including retrieving data from EHRs via FHIR APIs and other mechanisms?
  - Are there other critical considerations during the transition?

*Request for Information re: Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)*

As discussed elsewhere in the proposed rule, CMS is proposing to add a new Enabling Exchange Under TEFCA measure in the Promoting Interoperability performance category. This proposed measure would provide eligible clinicians with the opportunity to earn credit for the Health Information Exchange (HIE) Objective if they: are a signatory to a “Framework Agreement” as that term is defined in the Common Agreement; enable secure, bi-directional exchange of information to occur for all unique patients of eligible clinicians, and all unique patient records stored or maintained in the EHR; and use the functions of CEHRT to support bi-directional exchange.

In addition to this proposal, CMS is considering other ways that available CMS policy and program levers can advance information exchange under TEFCA. For instance, similar to the proposal in the current rule, there may be opportunities for CMS to incentivize exchange under TEFCA through other programs that incentivize high quality care, or through program features in value-based payment models that encourage certain activities that can improve care delivery. In addition to programs focused on health care professionals, CMS is interested in opportunities to encourage exchange under TEFCA through CMS regulations for certain health care payers, including Medicare Advantage, Medicaid Managed Care, and CHIP issuers. For instance, CMS believes there may be opportunities to encourage information exchange under TEFCA to support recently finalized requirements for these payers to make information available to patients and to make patient information available to other payers as beneficiaries transition.
between plans in the “Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers” final rule. Finally, CMS is considering future opportunities to encourage information exchange under TEFCA for payment and operations activities such as submission of clinical documentation to support claims adjudication and prior authorization processes.

CMS is requesting input from the public on the ideas described previously and related concepts for future exploration, as well as the following questions:

- What are the most important use cases for different groups that could be enabled through widespread information exchange under TEFCA? What key benefits would be associated with effectively implementing these use cases, such as improved care coordination, reduced burden, or greater efficiency in care delivery?
- What are key ways that the capabilities of TEFCA can help to advance the goals of CMS programs? Should CMS explore policy and program mechanisms to encourage exchange between different interested parties, including those in rural areas, under TEFCA? In addition to the ideas discussed previously, are there other programs CMS should consider in order to advance exchange under TEFCA?
- How should CMS approach incentivizing or encouraging information exchange under TEFCA through CMS programs? Under what conditions would it be appropriate to require information exchange under TEFCA by interested parties for specific use cases?
- What concerns do commenters have about enabling exchange under TEFCA? Could enabling exchange under TEFCA increase burden for some interested parties? Are there other financial or technical barriers to enabling exchange under TEFCA? If so, what could CMS do to reduce these barriers?

**Updates and Modifications to the Quality Payment Program**

Under MACRA, 2015, the QPP was established. CMS is proposing several changes to the QPP which include limited changes to traditional MIPS, additions and modifications to the MIPS Value Program (MVPs), and substantial changes to the Medicare Shared Savings Program (MSSP) financial methodology.

**Traditional MIPS**

*Quality Performance Category*

The Quality performance category will remain at 30 percent of a clinician’s final score for future performance years. This category weight was established in previous rulemaking by statute.

CMS is proposing to modify the definition of a high priority measure to include health equity-related quality measures. Previously, a high priority measure was defined as an outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure.
CMS is proposing several changes to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey measure. CMS would like to include questions on health disparities and price transparency to gain information on these two areas. Additionally, CMS would like to modify the CAHPS for MIPS measure case-mix adjustors. Currently, the case-mix adjustment model for the CAHPS for MIPS Survey measure includes age, education, self-reported general health status, self-reported mental health status, proxy response, Medicaid dual eligibility, eligibility for Medicare’s low-income subsidy, and Asian language survey completion as factors. CMS would like to replace the “Asian language survey completion” case-mix factor to “language other than English spoken at home” to capture language preference more accurately. Finally, CMS is proposing the creation of a shorter CAHPS for MIPS Survey measure that would be more applicable to specialty groups.

There are several new measures relevant to internal medicine clinicians proposed for adoption in the CY23 performance period:

- **Screening for Social Drivers of Health**: This measure evaluates the number of patients older than 18 that are screened for food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety.
- **Kidney Health Evaluation**: This measure evaluates the percentage of patients aged 18-75 years with a diagnosis of diabetes who received a kidney health evaluation defined by an Estimated Glomerular Filtration Rate (eGFR) AND Urine Albumin-Creatinine Ratio (uACR).
- **Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy**: This measure evaluates the percentage of patients aged 18 years and older with a diagnosis of chronic kidney disease (CKD) (Stages 1-5, not receiving Renal Replacement Therapy (RRT)) and proteinuria who were prescribed ACE inhibitor or ARB therapy within a 12-month period.
- **Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System**: The annual risk-standardized rate of acute, unplanned cardiovascular-related admissions among Medicare Fee-for-Service (FFS) patients aged 65 years and older with heart failure (HF) or cardiomyopathy.
- **Adult Immunization Status**: This measure evaluates the percentage of patients 19 years of age and older who are up to date on recommended routine vaccines for influenza; tetanus and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap); zoster; and pneumococcal.

**Quality Category Data Completeness**

The data completeness criteria threshold has slowly increased from 50 percent since the inception of the MIPS program in 2017. Average data completeness rates for the CY17 performance period were 76.14 for individual clinicians, 85.27 for clinician groups, and 74.76 for small practices. Based on this data, CMS is proposing to increase the data completeness criteria threshold from 70 percent to 75 percent for the CY24 and CY25 performance years. This higher data completeness threshold ensures a more accurate assessment of MIPS-eligible clinicians quality performance. For the CY23 performance period, the data completeness will remain at 70 percent as finalized in last year’s PFS.

**Cost Performance Category**

In this rule, CMS is proposing to update the operational list of care episode and patient condition groups...
and codes by adding the Medicare Spending Per Beneficiary (MSPB) Clinician cost measure as a care episode group.

CMS is proposing to add the MSPB Clinician measure to the operational list as a care episode group. This measure accounts for the patient’s clinical diagnoses at the time of an inpatient hospitalization and includes the costs of services furnished during an episode of care similarly to other episode-based cost measures. As a defined episode that uses the same attribution logic as the acute inpatient medical episode-based measures, CMS believes the MSPB Clinician measure should fall into the same operational list.

**Performance Threshold, Payment Adjustment and Scoring**

CMS is proposing to continue using the mean final score of 75 points from the CY 2017 MIPS performance year as the performance threshold for the CY 2023 MIPS performance year. CY 2022 is the last year that the additional exceptional performance threshold (85 points) will be in effect.

**Quality Performance Category Scoring**

To calculate scores for administrative claims quality measures, CMS is proposing to use benchmarks calculated from data collected during the applicable performance period. Previously, CMS used historical benchmarks to score administrative claims when available. Using performance period benchmarks will allow for more accurate scoring based on current performance.

CMS did not modify any previous scoring methodology in this year’s PFS. Measures that do not meet the case minimum (20 cases) or historical/performance period benchmark requirements are excluded from MIPS-eligible clinicians’ quality performance category score.

**Cost Performance Category Scoring**

CMS is proposing to establish a maximum cost improvement score of one percentage point out of 100 percentage points available for the cost performance category starting with the CY22 performance period. As CMS did not establish a maximum improvement score in prior rulemaking, this proposal would clarify the improvement scoring policy. CMS may consider increasing the maximum in future years after clinicians become more familiar with cost measurement.

**Improvement Activities**

In the 2022 PFS final rule, CMS finalized that in the case of an IA for which there is a reason to believe that the continued collection raises possible patient safety concerns or is obsolete, the Agency would promptly suspend the IA and immediately notify clinicians and the public through the usual communication channels, such as listservs and Web postings.

The Agency established two new criteria for nominating new IAs:

- Should not duplicate other IAs in the inventory; and
- Should drive improvements that go beyond standard clinical practices.

In this proposed rule, CMS is proposing the addition of four new improvement activities, modify five existing improvement activities, and remove six previously adopted improvement activities for the CY23 performance period/CY25 MIPS payment year and future years.
TABLE 6: Proposed Additions, Changes, and Removal of Improvement Activities

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<thead>
<tr>
<th>New</th>
<th>Modified</th>
<th>Removed</th>
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<tbody>
<tr>
<td><strong>IA_AHE_XX</strong>, Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data</td>
<td><strong>IA_CC_13</strong>, Practice Improvements for Bilateral Exchange of Patient Information</td>
<td><strong>IA_BE_7</strong>, Participation in a QCDR, that promotes use of patient engagement tools. Reasoning: Duplicative</td>
</tr>
<tr>
<td><strong>IA_AHE_XX</strong>, Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients</td>
<td><strong>IA_CC_14</strong>, Practice improvements that engage community resources to support patient health goals</td>
<td><strong>IA_BE_8</strong>, Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive. Reasoning: Duplicative</td>
</tr>
<tr>
<td><strong>IA_EPA_XX</strong>, Create and Implement a Language Access Plan</td>
<td><strong>IA_AHE_XX</strong>, Practice Improvements that Engage Community Resources to Address Drivers of Health</td>
<td><strong>IA_PM_7</strong>, Use of QCDR for feedback reports that incorporate population health Reasoning: Duplicative</td>
</tr>
<tr>
<td><strong>IA_ERP_XX</strong>, COVID-19 Vaccine Achievement for Practice Staff</td>
<td><strong>IA_PSPA_7</strong>, Use of QCDR data for ongoing practice assessment and improvements</td>
<td><strong>IA_PSPA_6</strong>, Consultation of the Prescription Drug Monitoring program Reasoning: Duplicative</td>
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<td></td>
<td><strong>IA_PSPA_10</strong>, Completion of training and receipt of approved waiver for provision opioid medication assisted treatments</td>
<td><strong>IA_PSPA_20</strong>, Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes Reasoning: Duplicative</td>
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<td><strong>IA_BMH_XX</strong>, Obtain or Renew an Approved Waiver for Provision of Buprenorphine as Medication-Assisted Treatment for Opioid Use Disorder</td>
<td><strong>IA_PSPA_30</strong>, PCI Bleeding Campaign Reasoning: Obsolete (PCI concluded in 2021)</td>
</tr>
<tr>
<td></td>
<td><strong>IA_PSPA_19</strong>, Implementation of formal quality improvement methods, practice changes, or other practice improvement processes</td>
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**Promoting Interoperability**

CMS is proposing to discontinue automatic reweighting for the following clinician types beginning with 2023: nurse practitioners, physician assistants, certified registered nurse anesthetists, and clinical nurse specialists. This rule would continue automatic reweighting for the following clinician types in 2023: clinical social workers, physical therapists, occupational therapists, qualified speech-language
pathologists, qualified audiologists, clinical psychologists, and registered dieticians or nutrition professionals.

Additionally, when participating in MIPS at the APM Entity level, CMS would allow APM Entities to report Promoting Interoperability data at the APM Entity level. However, APM Entities would still have the option to report this performance category at the individual and group levels.


CMS’ proposed modifications to the levels of active engagement for the Public Health and Clinical Data Exchange Objective measures include combining Options 1 (completed registration to submit data) and 2 (testing and validation) into a single option titled “Pre-production and Validation” and renaming Option 3 (production) to “Validated Data Production” for a total of two options. MIPS-eligible clinicians would also be required to submit their level of active engagement in addition to requiring a yes/no response for the required Public Health and Clinical Data Exchange measures. Option 1 would be limited in the time clinicians can stay within it to one year.

The Agency proposes modifications to the Query of Prescription Drug Monitoring Program (PDMP) Measure would become mandatory beginning with the 2023 performance period, with added exclusions to the measure and reweighting to 10 points. The scope of the measure would also be expanded to include not only Schedule II opioids but also Schedules III and IV drugs.

To offer health care professionals more opportunities to earn credit for the HIE Objective and given the alignment between enabling exchange under TEFCA and the existing HIE Bi-Directional Exchange measure, CMS is proposing to add an additional measure through which a MIPS-eligible clinician could earn credit for the HIE Objective by connecting to an entity that connects to a QHIN or connecting directly to a QHIN. Specifically, CMS is proposing to add the following new measure to the HIE Objective beginning with the performance period in CY23: Enabling Exchange Under TEFCA measure. CMS proposes MIPS-eligible clinicians would have three reporting options for the HIE Objective:

1. Report on both the Support Electronic Referral Loops by Sending Health Information measure (or the exclusion, if applicable) and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure (or the exclusion, if applicable);
2. Report on the HIE Bi-Directional Exchange measure; or

CMS proposes the Enabling Exchange Under TEFCA measure would be worth the total amount of points available for the HIE Objective. Under the current scoring methodology finalized in the CY21 PFS final rule, the HIE Objective is worth a total of 40 points. Elsewhere in the 2023 proposed rule, the Agency is proposing changes to the scoring methodology beginning with the performance period in CY23 such that the HIE Objective would be worth no more than 30 points. Therefore, under CMS’s proposal, the proposed Enabling Exchange Under TEFCA measure would be worth 30 points. CMS is proposing this change to the scoring methodology as a result of another proposal in a different section of this proposed rule to make the Query of PDMP measure required and worth 10 points. However, should CMS not finalize the Query of PDMP measure proposal, they propose the Enabling Exchange Under TEFCA measure would be worth 40 points (the current total point value of the HIE Objective). In no case could more than 40 points total be earned for the HIE Objective.
CMS is proposing a MIPS-eligible clinician would report the Enabling Exchange Under TEFCA measure by attestation, and the measure would require a “yes/no” response. A “yes” response would enable a MIPS-eligible clinician to earn the proposed 30 points allotted to the HIE Objective. CMS proposes that a MIPS-eligible clinician would attest to the following:

- Participating as a signatory to a Framework Agreement (as that term is defined by the Common Agreement for Nationwide Health Information Interoperability as published in the Federal Register and on ONC’s website) in good standing (that is, not suspended) and enabling secure, bi-directional exchange of information to occur, in production, for every patient encounter, transition or referral, and record stored or maintained in the EHR during the performance period, in accordance with applicable law and policy.

- Using the functions of CEHRT to support bi-directional exchange of patient information, in production, under this Framework Agreement.

Similar to the HIE Bi-Directional Exchange measure, to successfully attest to this measure, CMS proposes that a MIPS-eligible clinician must use the capabilities of CEHRT to support bi-directional exchange under a Framework Agreement, which includes capabilities that support exchanging the clinical data within the Common Clinical Data Set (CCDS) or the United States Core Data for Interoperability (USCDI). This is consistent with the other measures under the HIE Objective, which point to the use of CEHRT to support the exchange of the clinical data within the CCDS or the USCDI.

CMS recognizes that entities that will connect directly or indirectly to a QHIN are currently interacting with physicians using certified health IT in a variety of ways, and as with the Bi-Directional HIE Exchange measure, believes that the Agency should allow for substantial flexibility in how physicians use certified health IT to exchange data under a Framework Agreement.

The Enabling Exchange Under TEFCA measure would not require a MIPS-eligible clinician to assess whether they participate in a health information exchange that meets the attributes of attestation Statement 2 under the HIE Bi-Directional Exchange measure regarding exchange across a broad network of unaffiliated exchange partners, including those using disparate EHRs.

CMS is inviting public comment on these proposals and is also requesting comment on other ways that TEFCA can advance CMS policy and program objectives, including how TEFCA can support exchange of information required under other measures in the Promoting Interoperability performance category. For instance, how can TEFCA support exchange of information specified under the Public Health and Clinical Data Exchange and the Patient Access to their Health Information objectives?

**Screening for Social Drivers of Health Proposed Measure**

CMS has made a commitment to advancing health equity by addressing and reducing health disparities as outlined in their strategic plan. In alignment with that goal, CMS has proposed a measure entitled, “Screening for Social Drivers of Health” for inclusion in MIPS. CMS believes that this measure represents an important first step in detecting factors that lead to inadequate health care access and adverse health outcomes among patients. The standard identification of these needs will support clinician practices and health systems to collaborate with other clinicians and organizations to develop innovations in health care and social service delivery.

**Public Health Reporting and Information Blocking**
CMS notes that ONC recently released an information blocking frequently asked questions (FAQs) (IB.FAQ43.1.2022FEB) that highlights important points about public health reporting and information blocking. Specifically, if an actor is required to comply with another law that relates to the access, exchange, or use of EHI, failure to comply with that law may implicate the information blocking regulations. As an example, where a law requires actors to submit EHI to public health authorities, an actor’s failure to submit EHI to public health authorities could be considered an interference under the information blocking regulations. For example, many States legally require reporting of certain diseases and conditions to detect outbreaks and reduce the spread of disease. Should an actor that is required to comply with such a law fail to report, the failure could be an interference with access, exchange, or use of EHI under the information blocking regulations. Practices would be evaluated to determine whether the unique facts and circumstances constitute information blocking, consistent with additional ONC FAQs.

Request for Information re: Patient Access to Health Information Measure

The proposed rule includes an RFI to collect information on patients’ access to their health information through the use of portals, which has been tied to benefits such as improvements in access, quality of care, and health outcomes, as well as reductions in health care expenditures. In particular, access to health information has been shown to enable the discovery of medical errors, to improve medication adherence, and to promote communication between the patient and health care professional. The Health Information National Trends Survey (HINTS), a large, nationally representative survey operated by the National Cancer Institute (with support from ONC), is conducted routinely and contains key utilization data on consumer access and use of their online medical record through patient portals. Results showed that health care professionals and staff have a substantial role in influencing patient use of the portal. Through the current Provide Patients Electronic Access to Their Health Information measure in the Provider to Patient Exchange Objective, CMS is ensuring that patients have access to their health information through any application of their choice that is configured to meet the technical specifications of the API in the CEHRT of the MIPS-eligible clinician. CMS believes that promoting the use of API-enabled applications that provide timely access to updated information whenever the patient needs that information is an integral step in enhancing patient access and use of their health information.

CMS continues to believe in the importance of taking a patient-centered approach to health information access and moving to a system in which patients have immediate access to their electronic health information and can be assured that their health information will follow them as they move throughout the health care system. Recognizing the concerns and barriers with the previous “view, download, and transmit” (VDT) measure discussed previously, but acknowledging the advancements made within the health IT industry over the past few years, this request for information is seeking a broad array of public comments regarding how to further promote equitable patient access and use of their health information without adding unnecessary burden on the MIPS-eligible clinician or group. Specifically, CMS is seeking public comment on the following questions:

- Moving beyond providing the information and technical capabilities to access their data, are there additional approaches to promote patient access and use of their health information? Are there examples of successful approaches or initiatives that have enhanced patient access and use of their health information?
Would allowing patients to add information to their records be useful in promoting patient access and utilization? Are there other incentives that would promote patient access?

Are there potential unintended consequences in allowing patients to add information to their records? What could be done to mitigate any potential unintended consequences?

Are there certain tools found to be useful in promoting patient access and use of their health information?

Recent studies have raised concerns about the presence of racial bias and stigmatizing language within EHRs that could lead to unintended consequences if patients were to obtain disparaging notes regarding their medical care.

What policy, implementation strategies, or other considerations are necessary to address existing racial bias or other biases and prevent use of stigmatizing language?

Additional analysis of HINTS data provides insights into common barriers to patient portal access and use as well as characteristics that can help predict which individuals are more likely to experience certain barriers (for example, preference for in-person communication with their health care professionals is one of the most prevalent barriers experienced more often by older adults and women).

What are the most common barriers to patient access and use of their health information that have been observed? Are there differences by populations or individual characteristics? For example, are there barriers caused by lack of accessibility to patients due to disability or limited English proficiency?

Patients’ health information may be found in multiple patient portals. How could CMS or HHS facilitate individuals’ ability to access all their health information in one place?

If patient portals connected to a network participating in the recently launched TEFCA, would this enable more seamless access to individual health information across various patient portals?

With the advancement of HIT, EHRs and other health-related communication technologies, there are concerns that implementation of these technologies can lead to unintended consequences that exacerbate existing health disparities within populations who could receive greater benefits but are less likely to adopt them. What policy, governance, and implementation strategies or other considerations are necessary to ensure equal access to consumer-facing health technologies such as patient portals and mobile health applications, as well as equitable implementation and appropriate design and encouragement of use across all populations?

What challenges do MIPS-eligible clinicians face when addressing patient questions and requests resulting from patient access of patient portals or access of data through use of a mobile app? What can be done to mitigate potential burden?

For patients who access their health information, how could CMS, HHS, and health care practitioners help patients manage their health through the use of their personal health information?

Do you believe the API and larger application ecosystem are at the point where it would be beneficial to revisit adding a measure of patient access to their health information which assesses clinicians on the degree to which their patients actively access their health information? What should be considered when designing a measure of patient access of their health information through portals or applications?
CMS welcomes input on how the Agency can encourage and enable patient access to and use of their health information to manage and improve their care across the care continuum.

**MIPS Value Pathway (MVPs)**

*MVP Vision Overview*

CMS reiterated their vision for MVPs as transforming traditional MIPS to meet their intended goal of improving value, reducing burden, and informing patient choice in selecting clinicians. Additionally, MVPs are intended to serve as a starting point on the path to APMs. The Agency also stated its intent to move towards a future in which MVPs are the only MIPS reporting option. CMS did not state a timeframe for this transition.

CMS outlined how its intent for MVPs and APMs to advance health equity consistent with the five priorities included in CMS’s Framework for Health Equity:

1. Expand the collection, reporting and analysis of standardized data;
2. Assess causes of disparities within CMS programs, and address inequities in policies and operations to close gaps;
3. Build capacity of health care organizations and the workforce to reduce health and health care disparities;
4. Advance language access, health literacy, and the provision of culturally tailored services; and
5. Increase all forms of accessibility to health care services and coverage.

*MVPs and APM Participant Reporting Request for Information (RFI)*

CMS has developed MVP and subgroup reporting policies to provide meaningful MIPS performance measurement for both primary care and specialist clinicians. CMS described its goal of developing an MVP portfolio that balances the MVP goals for transformative change and the five MVP guiding principles within current CMS and clinician practice capabilities.

CMS recognizes that there remains a need to identify the best coordination and alignment between MVPs and APMs. The Agency noted that it would continue to explore the ideal MVP relationship with APMs to drive value.

CMS highlighted the significant APM participation rates (42.7 percent) among the 933,547 MIPS-eligible clinicians receiving a MIPS payment adjustment for the 2020 performance year. However, the Agency recognizes a gap in the availability of 2022-2024 APMs available for specialties may not fully represent the services provided and the patients treated by all clinician types in a group.

CMS commented on its belief that MVPs will serve an important role in furthering specialty measurement. The Agency also highlighted the integral role of primary care measurement within MIPS. MVP reporting is intended to complement APP reporting such that it will enhance performance measurement and available information while minimizing the current complexities and additional burden.

*MVP Development*
CMS understands the need to gather input from a broad group of stakeholders in the development of MVPs. CMS has worked closely with clinicians and specialty societies to develop MVPs and consider new MVPs. The Agency would like to broaden the input it currently receives during the MVP development process. As a result, CMS has proposed a 30-day period where it will post candidate MVPs to seek comments from interested parties and the general public before the notice-and-comment rulemaking process.

**MVP Maintenance Process and Engagement with Interested Parties**

CMS described its intent to operationalize the annual maintenance process for MVPs. The Agency intends to establish a process for soliciting recommendations from interested parties for potential updates to finalized MVPs on a rolling basis throughout the year. CMS shared that these comments would be shared with the developer of the MVP.

**Proposed Revisions to Previously Finalized MVPs**

CMS has described proposed revisions to the current seven MVPs:

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

**Proposed New MVPs**

The proposed five new MVPs:

- Advancing Cancer Care;
- Optimal Care for Kidney Health;
- Optimal Care for Neurological Conditions;
- Supportive Care for Cognitive-Based Neurological Conditions; and
- Promoting Wellness.

New MVPs will be prioritized that align with priorities which includes consideration of the various specialties and subspecialties that currently participate in MIPS, and identification of priorities of the Biden-Harris Administration and relevant Federal agencies.

**Promoting Wellness MVP**

In addition to the MVP for Optimizing Chronic Disease Management, ACP’s other MVP, Promoting Wellness, is proposed as follows:

**Quality Measures**

CMS is proposing to include fourteen MIPS quality measures within the quality component of the Promoting Wellness MVP:
• Q039: Screening for Osteoporosis for Women Aged 65-85 Years of Age: This MIPS quality measure assesses women, 65-85 years of age, who have ever received a dual-energy x-ray absorptiometry (DXA) test to evaluate for the disease osteoporosis.
• Q112: Breast Cancer Screening: This MIPS quality measure ensures women have a mammogram to screen and for breast cancer.
• Q113: Colorectal Cancer Screening: This MIPS quality measure ensures patients have received appropriate screening for colorectal cancer.
• Q309: Cervical Cancer Screening: This MIPS quality measure assesses women to determine if they were screened for cervical cancer.
• Q310: Chlamydia Screening for Women: This MIPS quality measure identifies women that are sexually active to ensure that they have had at least one test for chlamydia.
• Q400: One-Time Screening for Hepatitis C Virus (HCV) for all Patients: This MIPS quality measure requires that patients have received a one-time screening for hepatitis C virus (HCV) infection.
• Q475: HIV Screening: This MIPS quality measure ensures patients received a one-time test for HIV.
• TBD: Adult Immunization Status: This MIPS quality measure ensures patients are assessed for and/or receive the influenza, Tdap/Td, herpes zoster, and pneumococcal vaccines, as recommended.

Additionally, CMS proposes to include the following broadly applicable MIPS quality measures that are relevant to promoting wellness:

• Q128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan: This MIPS quality measure assesses patients, aged 18 years and older, with a BMI documented and who had a follow-up plan documented if their most recent documented BMI was outside of normal parameters.
• Q134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan: This MIPS quality measure ensures all patients are screened for depression with a follow-up plan discussed for those patients who screen positive.
• Q226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: This MIPS quality measure screens patients for tobacco use and if the patient is screened positive for tobacco use then they should receive tobacco cessation intervention.
• Q321: CAHPS for MIPS Clinician/Group Survey: This survey would provide direct input from patients and their experience regarding timely care, effective communication, shared decision making, care coordination, promotion of health and education, completion of health status/functionality, and courtesy of office staff.
• Q431: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling: This MIPS quality measure screens patients, aged 18 years and older, for unhealthy alcohol use using a systematic screening method at least once within the last 12 months. If the patient is screened positive for unhealthy alcohol use, then they should receive brief counseling.
• Q483: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM): This MIPS quality measure evaluates the high value aspects of primary care based on a patient’s relationship with the clinician or practice and allows patients the ability to communicate their perspective of the quality of care received to their clinicians and/or care team.

Improvement Activities
The following improvement activities are proposed for inclusion in this MVP:
• IA_AHE_3: Promote Use of Patient-Reported Outcome Tools;
• IA_BE_4: Engagement of patients through implementation of improvements in patient portal;
• IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings;
• IA_BE_12: Use evidence-based decision aids to support shared decision-making;
• IA_BMH_9: Unhealthy Alcohol Use for Patients with Co-occurring Conditions of Mental Health and Substance Abuse and Ambulatory Care Patients;
• IA_CC_2: Implementation of improvements that contribute to more timely communication of test results;
• IA_CC_13: Practice improvements for bilateral exchange of patient information;
• IA_CC_14: Practice improvements that engage community resources to support patient health goals;
• IA_EPA_1: Provide 24/7 Access to MIPS-eligible Clinicians or Groups Who Have Real-Time Access to Patient’s Medical Record;
• IA_PCMH: Electronic submission of Patient Centered Medical Home accreditation;
• IA_PM_11: Regular review practices in place on targeted patient population needs;
• IA_PM_13: Chronic Care and Preventative Care Management for Empaneled Patients;
• IA_PM_16: Implementation of medication management practice improvements; and
• IA_PSPA_19: Implementation of formal quality improvement methods, practice changes, or other practice improvement processes.

Cost Measures
Within the cost component of this MVP, CMS proposes to include the Total Per Capita Cost (TPCC) measure because it captures the total costs of care. CMS states that this broad cost measure aligns with the MVP scope to include a range of measures and activities to promote wellness across different clinical topics. Currently, there are no applicable episode-based measures available, but CMS suggests that one could be considered for development in the future.

Promoting Interoperability Measures
The following promoting interoperability measures are proposed for inclusion in this MVP:
• Security Risk Analysis;
• Safety Assurance Factors for EHR Resilience Guide (SAFER Guide);
• e-Prescribing;
• Query of the Prescription Drug Monitoring Program (PDMP);
• Provide Patients Electronic Access to Their Health Information;
• Support Electronic Referral Loops By Sending Health Information, AND
• Support Electronic Referral Loops By Receiving and Reconciling Health Information, OR
• Health Information Exchange (HIE) Bi-Directional Exchange, OR
• Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA);
• Immunization Registry Reporting;
• Syndromic Surveillance Reporting (Optional);
• Electronic Case Reporting;
• Public Health Registry Reporting (Optional);
• Clinical Data Registry Reporting (Optional);
• Actions to Limit or Restrict Compatibility or Interoperability of CEHRT; and
• ONC Direct Review.
Population Health Measures
The following population health measures are proposed for inclusion in this MVP:

- Q479: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Systems (MIPS) Eligible Clinician Groups (Collection Type: Administrative Claims).
- Q484: Clinician and Clinician Group Risk standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (Collection Type: Administrative Claims).

MVP Reporting Requirements
CMS does not intend to establish different reporting requirements for Promoting Interoperability measures in MVPs from what is established under traditional MIPS.

Reporting MVPs and Team-Based Care
CMS stated that MVPs have been constructed to reflect the team-based health care model. This approach considers the patient’s care from a holistic perspective, involving several clinician types in a manner that captures the patient’s experience and outcomes.

Currently, individual MIPS-eligible clinicians, single specialty groups, multispecialty groups, subgroups and APM entities may report MVPs. However, beginning with the CY26 performance period, multispecialty groups must form subgroups to report MVPs. This is consistent with CMS’ belief that data that is directly attributed to all clinicians in the group will better drive quality improvement and lead to improved patient outcomes.

The Agency encourages multispecialty groups to consider adopting subgroup reporting before it becomes mandatory in the CY26 performance period. Early adoption will allow clinicians within the subgroups to gain familiarity with reporting at the subgroup level before it becomes mandatory.

Scoring MVP Performance
CMS announced its intent to adopt scoring policies from traditional MIPS for MVP participants unless there is a compelling reason to adopt a different policy to further the goals of the MVP framework.

Scoring MVP Performance: Subgroup Reporting
The proposal for scoring MVP performance is different for subgroups. Several notable changes have been proposed:

- Modify the definitions of single specialty group and multispecialty group;
- Add subgroup description requirements to the registration process;
- Limit the number of subgroups a clinician may participate in to one subgroup per TIN;
- Establish the subgroup determination period;
- Apply new policies for scoring administrative claims measures and cost measures for subgroups; and
- Not assign a subgroup final score to registered subgroups that do not submit data.
Request for Information re: Risk Indicators for the Complex Patient Bonus Formula to Continue to Align with CMS Approach to Operationalizing Health Equity

CMS believes the complex patient bonus aligns with the following five focus areas, addressing the need for standardized data collection:

- Expand the Collection, Reporting, and Analysis of Standardized Data;
- Assess Causes of Disparities Within CMS Programs and Address Inequities in Policies and Operations to Close Gaps;
- Build Capacity of Health Care Organizations and the Workforce to Reduce Health and Health Care Disparities;
- Advance Language Access, Health Literacy, and the Provision of Culturally Tailored Services; and
- Increase All Forms of Accessibility to Health Care Services and Coverage.

The Agency continues to explore ways and efforts to improve current policies to advance health equity in ways that are responsive to the needs of stakeholders.

CMS is proposing a positive adjustment to the quality performance score for an Accountable Care Organization (ACO) that achieves a specified level of quality performance and serves beneficiaries in areas with a high Area Deprivation Index (ADI) or serves a large proportion of dual eligible beneficiaries. CMS is evaluating and inquiring whether the ADI measure is a good indicator of beneficiaries with high needs for use within the MIPS program as it is intended to capture local socioeconomic factors correlated with medical disparities and underservice.

The Agency is not currently proposing to use the ADI measure within the complex patient bonus but are seeking public comments on the potential future incorporation of the measure.

In considering a potential future definition of “safety net providers” in the context of the complex patient bonus, CMS is interested in input and information related to the definition of “Essential Community Providers” (ECPs) as defined in 45 CFR 156.235. Under that regulation, ECPs are defined as practitioners that serve predominantly low-income, medically underserved individuals. They include covered entities defined in section 340B(a)(4) of the Public Health Service (PHS) Act and entities described in section 1927(c)(1)(D)(i)(IV) of the Act. Additional practitioners may submit an online petition to be considered and approved by CMS for inclusion on the ECP list through the ECP petition review process.

Medicare Shared Savings Program (MSSP)

In recent years, various stakeholders within value-based care (VBC) have expressed the need for reduction of barriers to entry into VBC and necessary increased incentives for ACOs serving rural and/or otherwise underserved communities.

In response, CMS is proposing an incorporation of advanced shared savings for new, inexperienced ACOs who serve underserved beneficiaries which include:

- Allowing low-revenue ACOs, inexperienced with performance-based risk Medicare ACO initiatives, that are new to the Shared Savings Program (that is, not a renewing or re-entering ACO) to receive advance investment payments (AIPs) based on assigned beneficiary dual eligibility status and ADI national percentile rank of the census block group in which the
beneficiary resides. AIPs would include a one-time fixed payment of $250,000 and quarterly payments for the first two years of an ACO’s five-year agreement period. Quarterly payments would be based on a risk factors-based score set to 100 if the beneficiary is dually eligible for Medicare and Medicaid or set to the ADI national percentile rank (an integer between one and 100) of the census block group in which the beneficiary resides if the beneficiary is not dually eligible, with higher payment amounts for assigned beneficiaries with higher risk factors-based scores.

- Allowing ACOs applying to the program that are inexperienced with performance-based risk to participate in one five-year agreement under a one-sided shared savings model, in order to provide these ACOs more time to invest in infrastructure and redesigned care processes for high quality and efficient health care service delivery before transitioning to performance-based risk.
- Revise the limitation on the number of agreement periods an ACO can participate in BASIC track Level E.
- Revise the policies for determining beneficiary assignment:
  - Update the definition of primary care services used in beneficiary assignment; and
  - Identify how CMS certification numbers will be used in beneficiary assignment.
- Revise the quality reporting and the quality performance requirements for performance year 2023 and subsequent performance years.
- Establish an alternative quality performance standard for ACOs that do not meet the quality performance standard to share in savings at the maximum rate by reinstituting a sliding scale approach for determining shared savings for ACOs, regardless of how quality data is reported and revise the approach for determining shared losses for ENHANCED track ACOs.
- Establish a health equity adjustment that would upwardly adjust an ACO’s quality performance score, to reward ACOs that report all-payer eCQMs/MIPS CQMs, that are high performing on quality, and serve a high proportion of underserved beneficiaries. This proposed adjustment would add up to 10 bonus points to the ACO’s MIPS quality performance category score. The resulting health equity adjusted quality performance score would be used to determine whether the ACO meets the quality performance standard set at the 30th percentile (for performance year 2023) or 40th percentile (for performance year 2024 and subsequent years) across all MIPS quality performance category scores; the final sharing rate for calculating shared savings payments under the BASIC track and the ENHANCED track for an ACO that meets the proposed alternative quality performance standard allowing for application of a sliding scale based on quality performance; and the shared loss rate for calculating shared losses under the ENHANCED track under the proposed modified approach to scaling shared losses. It would also be used when applying the extreme and uncontrollable circumstances policy for ACOs that report quality data via the APP and meet data completeness and case minimum requirements.
  - Extend the incentive for reporting eCQMs/MIPS CQMs through performance year 2024 to align with the sunsetting of the CMS Web Interface reporting option.
  - Change the nomenclature of the administrative claims measure Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for MIPS to Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions to align with the MIPS program.
  - Clarify use of unweighted MIPS Quality performance category scores to determine the quality performance standard under the Shared Savings Program.
- Clarify our policies on re-openings to address changes to MIPS quality performance category scores.
- Establish policies for benchmarking quality measures reported through the CMS Web Interface for performance year 2022 through performance year 2024.

- Revise the benchmarking methodology to reduce the effect of ACO performance on ACO historical benchmarks, increase opportunities for ACOs caring for medically complex, high-cost beneficiaries, strengthen incentives for ACOs to enter and remain in the Shared Savings Program, and meet the programmatic goals of improving quality of care and lowering growth in FFS expenditures:
  - Incorporate a prospectively projected administrative growth factor, a variant of the United States Per Capita Cost (USPCC) referred to in this proposed rule 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 and address increasing market saturation by ACOs in a regional service area.
  - Adjust benchmarks to account for prior savings, helping to mitigate lowering of an ACO’s benchmark over time by returning to an ACO’s benchmark an amount that reflects its success in lowering growth in expenditures from the previous agreement period.
  - Reduce the impact of negative regional adjustments on ACO benchmarks by reducing the cap on negative regional adjustments and gradually decreasing the negative regional adjustment amount as an ACO’s weighted-average prospective HCC risk score increases, or the proportion of dually eligible Medicare and Medicaid beneficiaries increases, or both.

- Change in how the Agency calculates regional factors used in benchmarking to increase internal consistency of benchmark calculations for ACOs under prospective beneficiary assignment by using an assignment window that is consistent with an ACO’s selected assignment methodology to identify the assignable population used to calculate regional FFS expenditures.

- Revision to how CMS applies the existing three percent cap on positive prospective HCC risk score growth to better account for medically complex, high-cost populations while continuing to guard against coding initiatives.

- Increase opportunities for low revenue ACOs participating in the BASIC track to share in savings by expanding the criteria ACOs can meet to qualify for shared savings payments.

- Discuss ongoing considerations regarding the impact of the PHE for COVID-19 on ACO expenditures, although there are no associated proposed revisions to the regulations currently.

- Exclude the proposed new supplemental payment under the Medicare Hospital Inpatient Prospective Payment System (IPPS) for Indian Health Service (IHS)/Tribal hospitals and hospitals located in Puerto Rico from the determination of Medicare Parts A and B expenditures for purposes of calculations under the Shared Savings Program.

- Remove the requirement to submit marketing materials prior to use. ACOs would be required to submit marketing materials only upon request from CMS, but the Agency would retain the requirement that an ACO must discontinue use of any marketing materials or activities for which CMS has issued a notice of disapproval.

- Amend the beneficiary notification requirements to reduce the frequency with which beneficiary information notices are provided to beneficiaries from annually to a minimum of once per agreement period, with a follow up beneficiary communication serving to promote
beneficiary comprehension of the standardized written notice and occurring no later than 180 days following the date that the standardized written notice was provided to the beneficiary.

- Amend the beneficiary notification requirements to clarify that ACOs and ACO participants are required to post signs in all facilities and make standardized written notices available upon request in all settings in which beneficiaries receive primary care services.
- Remove the requirement for an ACO to submit certain narratives when applying for the SNF three-day rule waiver and replace with a requirement that an ACO submit an attestation that it has established the narratives and will make them available to CMS upon request.
- Amend regulations to recognize ACOs structured as OHCAs for data sharing purposes.

**Advanced Alternative Payment Models (APMs)**

CMS has proposed a voluntary option for APM Entities to report the Promoting Interoperability performance category at the APM Entity level. The Agency has made a clarification regarding the criterion for Advanced APMs that payment which must be based on quality measures can be met using a single quality measure.

**APM Incentive**

Beginning in 2023, CMS proposes to remove the 2024 expiration of the eight percent minimum on the Generally Applicable Nominal Risk standard (eight percent of the average estimated total Medicare Parts A and B revenue of all practitioners and suppliers in participating APM Entities for the applicable QP performance period for Advanced APMs) and make the eight percent minimum permanent.

As mentioned previously, effective in the 2023 performance year, CMS is proposing to apply the 50-clinician limit to the APM Entity participating in the Medical Home Model. This would be actualized through the identification of the clinicians in the APM Entity by using the TIN/NPIs on the participation list of the APM Entity on each of the three QP determination dates (March 31, June 30, and August 31).

Beginning in performance year 2022, there is no further statutory authority to continue the five percent lump sum APM Incentive Payment. However, CMS is proposing to utilize a section of MACRA to apply two different conversion factors depending on the clinician’s QP status. The conversion factor for QP would update to 0.75 starting in payment year 2026. CMS is requesting comments on this gap in statutory financial incentives for QPs in the 2025 payment year after the APM bonus expires but before the 0.75 update to the conversion factor begins in 2026, and the difference in financial incentives between QPs and MIPS-eligible clinicians beginning in 2026.

Currently, to qualify for the bonus and/or reach the QP Threshold, clinicians must have 75 percent of payments or 50 percent of patients in the advanced APM. 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 that meet minimum quality reporting and performance requirements. Based on these statutory changes, CMS estimates that between 144,700 and 186,000 eligible clinicians would become QPs in the 2023 performance period, and therefore be excluded from MIPS.
Additionally, due to ACP’s advocacy to CMS on efforts to reduce administrative burden, the Agency is proposing an elimination of certain reporting requirements such as the submission of marketing materials before disbursement to ACOs and modification of beneficiary notification requirements.

Request for Information

CMS is requesting comments on the questions below:

- What are your primary considerations going forward as you choose whether to participate in an Advanced APM or be subject to MIPS reporting requirements and payment adjustments? What factors are the most important as you make this decision?
- If you are participating in an Advanced APM now and have been or could be a QP for a year, will the end of the five percent lump-sum APM Incentive Payments beginning in the 2025 payment year (associated with the 2023 QP Performance Period) cause you to consider dropping your participation in the Advanced APM, which would mean forgoing QP determinations, thereby ensuring you are subject to MIPS reporting requirements and payment adjustments?
- Going forward, attaining QP status for a year through sufficient participation in one or more Advanced APMs will enable an eligible clinician to, for a year. Do these three conditions provide sufficient incentives for you to participate in an Advanced APM, or would you instead decide to be subject to MIPS reporting requirements and payment adjustments?
  1. Continue receiving any financial incentive payments available under the Advanced APM(s) in which they participate, subject to the terms and conditions applicable to the specific Advanced APM(s);
  2. Be paid under the PFS in the payment year using a higher QP conversion factor (0.75 percent rather than 0.25 percent) beginning in payment year 2026; and
  3. Not be subject to MIPS reporting requirements or payment adjustments.
- Are there other advantages of MIPS participation that might lead a clinician to prefer MIPS over participation in an Advanced APM, such as:
  1. Quality measurement that may be specific to a particular practice area or specialty area; or
  2. The desire for more precise accountability through public reporting of quality measure performance in the future?