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CMS Issues 2023 Physician Fee Schedule Proposed Rule

On July 7, 2022, the Centers for Medicare & Medicaid Services (CMS) released its proposed Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2023. Arguably the most noteworthy provision in the proposed rule is the agency's suggested cut to physician payments. However, the rule also includes a number of other policy proposals, including changes to Medicare accountable care organizations (ACOs), behavioral health care, cancer screening, and dental care. According to CMS, "[i]f finalized, the proposals in this rule will advance equity, lead to better care, support healthier populations, and drive smarter spending of the Medicare dollar."[1]

Payment Rate Updates for MPFS

For 2023, CMS proposes to decrease the conversion factor by $1.53, to $33.08 (a 4.4% reduction from the 2022 conversion factor of $34.61).[2] Conversion factors are applied to relative value units (RVUs), i.e., the resources required to furnish a service, to become payment rates. Payment rate decreases for CY 2023 emanate from the statutory update of 0%, the end of the temporary 3% payment rate bump for 2022 pursuant to the *Protecting Medicare and American Farmers from Sequester Cuts Act*, and budget neutrality adjustments.[3]

The proposed conversion factor decrease for 2023 results from a March 2022 Medicare Payment Assessment Commission (MedPAC) report, which stated that Medicare payments to physicians do not need to be increased for 2022. This assertion is, expectedly, hotly contested by provider groups, as discussed further below.

Proposed Updates to Accountable Care Organizations

In an effort to combat stagnant growth in the program over the past few years, CMS included in the proposed rule several suggested changes to the Medicare Shared Savings Program (MSSP) that, if finalized, will "represent some of the most significant reforms since the final rule that established the program was finalized in November 2011 and ACOs began participating in 2012."[4]

In order to provide smaller providers with no previous ACO experience more time to acclimate to two-sided risk, CMS proposes extending the amount of time during which these providers may participate in one-sided (no risk) shared savings models. If finalized, these ACOs would be able to spend up to seven years in a one-sided model.[5]

In furtherance of its focus on health equity,[6] CMS proposes incorporating advance shared savings payments (a $250,000 one-time payment and quarterly payments for two years thereafter based on "enrollee neediness") to low-revenue ACOs, which can be used to address social needs of Medicare beneficiaries.[7] For example, the funds could be used to improve provider infrastructure, increase staffing, or care for underserved enrollees.[8] These funds would then be repaid to CMS through the ACO's shared savings (if it earns any). If finalized, this will be one of the first times traditional Medicare payments would be permitted for such uses.[9]

Additionally, CMS seeks to fix "glitches" in the MSSP's benchmarks that make it progressively harder to top the previous year's metrics. Toward that end, the agency proposes adding a prospective (rather than an historical) external factor, and including a prior savings adjustment in historical benchmarks. CMS also proposes reducing the cap on negative regional adjustments, from 5% to 1.5% of national per capita expenditures, for Parts A and B services.[10]

In total, these proposed changes could result in $650 million more in shared savings payments to ACOs and a $15.5 billion decrease in benefits spending (as a result of savings from efficiency).[11]

Other Proposals

First, CMS recommends the removal of various barriers to behavioral healthcare, such as by allowing certain types of behavioral health practitioners to provide services under general, rather than direct, supervision. CMS also proposes bundling "certain chronic pain management and treatment services into new monthly payments" to facilitate team-based care and covering opioid treatment and recovery services that are provided from mobile units.[12]

Second, CMS introduced a number of ideas for improving access to screening for colon cancer, the second leading cause of cancer deaths in 2020.[13] CMS is proposing that colonoscopies performed as a follow up to an at-home test be classified as a preventative service, which allows cost sharing to be waived for Medicare beneficiaries. Additionally, CMS is seeking to cover colonoscopies for individuals age 45+.[14]

Third, CMS plans to extend coverage for some dental services, including dental exams and treatment prior to an organ transplant. The agency is also seeking comment

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regarding other medical conditions for which Medicare should pay for dental services.[15] Currently, Part B only pays for dental services that are "integral to medically necessary services required to treat a beneficiary's primary medical condition."[16]

Comments from Stakeholders

Many stakeholders have sharply criticized CMS for the over-4% reduction in the proposed conversion factor. The president of the American Medical Association (AMA) stated that:

> "It is immediately apparent that the rule not only fails to account for inflation in practice costs and COVID-related challenges to practice sustainability, but also includes a significant and damaging across-the-board reduction in payment rates. Such a move would create long-term financial instability in the Medicare physician payment system and threaten patient access to Medicare-participating physicians."[17]

The Surgical Care Coalition, led by the American College of Surgeons (ACS), claimed that CMS "once again jeopardizes seniors' access to critical treatments and procedures."[18] The organization urged Congress "to immediately stop these cuts to protect patients and work toward finding a long-term solution that promotes quality care and investment."[19]

Similarly, the Medical Group Management Association (MGMA) is concerned about the likely impact of the proposed reduction to the conversion factor, especially in light of the financial uncertainty which medical groups have faced over the past two years stemming from the COVID-19 pandemic, inflation, and the staffing crisis."[20] MGMA also made the important point that these cuts could be compounded by the Pay-As-You-Go Act (PAYGO) sequestration scheduled to take effect on January 1, 2023. This law requires that "all new legislation changing taxes, fees, or mandatory expenditures, taken together…not increase projected deficits" and "is enforced by the threat of automatic across-the-board cuts in selected mandatory programs [including most Medicare payments] in the event that legislation taken as a whole does not meet the PAYGO standard."[21] Consequently, Medicare payments could be cut by an additional 4% (the maximum amount allowed by law) for the next several years, barring congressional intervention; it is worth noting, however, that the PAYGO sequester has never gone into effect.[22] Therefore, it is likely that Congress will take action to avoid this cut before it goes into effect in January.

In contrast, the National Association of Accountable Care Organizations (NAACOs) commended CMS for "taking steps to reach its goal of creating a stronger Medicare by strengthening accountable care models and speed the movement toward value for all patients."[23]

Conclusion

While proposed payment changes in the CY 2023 MPFS were not well-accepted by stakeholders given the current healthcare environment, many applauded CMS for the other proposed changes. CMS is open to comments and information on requested topics until September 6, 2022; the final rule will be released sometime thereafter.[24]

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