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Proposed CY 2023 Medicare Physician Fee Schedule Yields Decrease in Reimbursement

The Centers for Medicare and Medicaid Services (CMS) released the Proposed Calendar Year 2023 Physician Fee Schedule on July 7. While the proposed conversion factor decrease was expected in light of budget neutrality requirements, the reality is that Medicare reimbursement to physicians and advance practice providers (APPs) will decline from current levels in 2023 at the same time medical practices are facing inflationary challenges. Industry groups have already been lobbying Congress to intervene, and that effort is likely to intensify between now and January 1, 2023. Below is a recap of the key provisions contained in the proposed rule, as well as other relevant factors that will impact overall Medicare reimbursement.

Conversion Factor

Medicare reimbursement for professional services is generally determined by multiplying the applicable relative value unit (RVU) amounts for billed services by the conversion factor in place on the date the service was rendered (adjusted for the specific locality). Typically, the conversion factor does not change significantly from year to year, given that CMS is required by law to maintain budget neutrality. However, the conversion factor decreased substantially in 2021 in response to significant increases in Work RVUs (wRVUs) for many office visits and similar services that were determined to be undervalued historically. Initially, the 2021 conversion factor was set to be $32.41, but Congress intervened and approved a 3.75% adjustment, which resulted in only a 3.3% reduction from 2020 rather than 10.2%. Similarly, the conversion factor for 2022 was set to be $33.59 based on the fee schedule issued by CMS (a 3.7% decline from 2021), but again the rate was increased at the last minute as a result of legislation that provided a 3% adjustment. However, this legislation stipulated that 2023 rate needed to be determined by CMS without the benefit of the 3% increase.

To recap, below is a summary of the Conversion Factor (after legislative adjustments) and the Anesthesia Conversion Factor for the last several years:

Year	Conversion Factor	% Change	Anesthesia Conversion Factor	% Change
2019	$ 36.0391		$ 22.2730	
2020	$ 36.0896	0.1%	$ 22.2016	(0.3%)
2021	$ 34.8931	(3.3%)	$ 21.5600	(2.9%)
2022	$ 34.6062	(0.8%)	$ 21.5623	0.0%
2023 (Proposed)	$ 33.0775	(4.4%)	$ 20.7191	(3.9%)
Cumulative Change: 2019 - 2023	$ (2.96)	(8.2%)	$ (1.55)	(7.0%)

Sequestration Impact

It should be noted that the conversion factor reflected in the Medicare Physician Fee Schedule (PFS) is prior to any reduction for sequestration. A 2% Medicare sequestration cut stems from a 2011 law that required across-the-board spending cuts for the federal government from fiscal year (FY) 2013 to FY 2030. Under this law, Medicare cuts cannot exceed 2%. Subsequent legislation suspended the application of sequestration to Medicare from May 1, 2020 through December 31, 2021, to provide relief to providers during the COVID-19 pandemic. The same legislation that increased the 2022 PFS conversion factor also further delayed sequestration and invoked a phased-in return. Accordingly, there was no sequestration adjustment for services rendered January 1 through March 31, 2022. A 1% reduction resumed from April 1 through June 30, 2022, with the full 2% cut resuming effective July 1, 2022. To make up for the moratorium, the sequestration adjustment will increase to 2.25% from October 1, 2029 to March 31, 2030, and to 3% from April 1, 2030 to September 30, 2030. The sequestration adjustment only applies to the portion of the payment made by Medicare and excludes the patient share.

In addition to sequestration, the Statutory Pay-As-You-Go Act ("PAYGO") was enacted in 2010 and requires spending cuts across the federal government if legislation enacted in a year results in a deficit increase. Medicare cuts resulting from this law cannot exceed 4%. To date, PAYGO has been waived by Congress to avoid cuts going into effect, but it is currently set to resume effective January 1, 2023.

With physician services provided to Medicare beneficiaries in 2023 subject to both the 2% sequestration and 4% PAYGO cuts, the actual reimbursement will be closer to a 10% reduction from pay rates in effect for the first quarter of 2022.

Other Provisions

The 2023 PFS Proposed Rule contains additional provisions that impact billing and reimbursement for a variety of services. Key components are recapped below.

Split/Shared Visits

The 2022 PFS final rule contained phased-in changes for billing inpatient split/shared visits. Split/Shared visits are those inpatient E&Ms where the service is jointly provided by a combination of a physician and a non-physician provider (NPP). The 2022 PFS final rule required that beginning in 2023 such visits must be billed under the provider number of the individual providing more than half of the total visit time. The 2023 PFS Proposed Rule delays implementation of that rule until 2024. Instead, billing for 2023 is proposed to be the same as 2022, which allows a choice in determining which clinician provided the "substantive portion" of the visit: If the physician performs the history, physical exam, or medical decision-making, or spends more than half the total time with the patient, the visit may be billed under the physician's provider number. Otherwise, it must be billed under the NPP's number, which results in a 15% reduction to the reimbursement rate.

Telehealth Services

There has been a great deal of attention regarding how telehealth services will be treated after the public health emergency (PHE) ends. During the pandemic, CMS implemented several policy changes to allow more widespread usage of, and reimbursement for, telehealth services. Legislation passed earlier this year allowed for current rules to remain in effect for 151 days after expiration of the PHE. Currently, the PHE is set to expire July 15, 2022; however, it is widely expected to be extended for at least one more 90-day period (through October 13). The Department of Health and Human Services (HHS) has assured state Medicaid administrators that a 60-day notice will be provided before the PHE is allowed to expire, and to this point no such notice has been provided.

The 2023 PFS Proposed Rule incorporates the 151-day extension of telehealth services as prescribed by the *Consolidated Appropriations Act, 2022*, and also proposes to make certain services temporarily

available during the PHE available throughout 2023 on a Category 3 basis before determining whether they should be permanently added to the Medicare telehealth services list. Category 3 is a category for services that were added to the approved list of telehealth services during the pandemic, and "for which 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 addition, CMS is proposing that the appropriate place of service indicators be used beginning after the 151-day period following the expiration of the PHE, instead of the "95" modifier that is currently utilized. In the event the telehealth service is provided via audio-only technology (rather than audio-visual), a modifier of "93" should be used.

Behavioral Health

To address the increased need for mental health services, the 2023 PFS Proposed Rule contains provisions that would create a new behavioral health integration service that would allow clinical psychologists or clinical social workers to account for monthly care integration when such individual is "serving as the focal point of care coordination." In addition, the rule proposes to allow certain behavioral professionals (e.g., licensed professional counselors and licensed marriage and family therapists) to provide care under general rather than direct supervision of a physician or NPP when their services are provided incident to the services of a physician or NPP.

Chronic Pain Management

In the Proposed Rule, CMS has added new HCPS codes for chronic pain management and treatment. These codes include a bundle of services typically rendered during a month that would allow for a more holistic approach to treating chronic pain.

Audiology Services

The 2023 PFS Proposed Rule would allow audiologists to provide certain services for non-acute hearing conditions on an annual basis without a physician referral, and bill for such services using a new HCPS code. These services include exams for the purpose of prescribing, fitting, or changing hearing aids. The proposal specifically excludes balance assessments for patients with disequilibrium, noting that there are a wide variety of causes for such condition and a physician or NPP should be involved in the initial assessment in such cases.

Colorectal Cancer Screening

Given recent changes to lower the recommended age for colorectal cancer screening, CMS is proposing to allow coverage for such screenings beginning at age 45. Additionally, a follow-on screening colonoscopy after a positive result on a non-invasive stool-based colorectal cancer screening test covered by Medicare would also be covered as a screening test rather than a diagnostic test as is the current practice. This is an effort to encourage more patients to obtain the appropriate follow-up test, and to acknowledge recent evidence-based recommendations that the follow-up test is necessary "for the screening benefits to be achieved." This is an important distinction since Medicare covers screening tests at 100% while diagnostic tests require cost-sharing by the beneficiary.

Dental & Oral Health Services

CMS is proposing to "clarify and codify" its current payment policy for dental service such that medically necessary dental services provided by a physician or practitioner, including a dentist, are reimbursable through Medicare. Accordingly, the proposal would "codify that payment can be made under Medicare Part A and Part B for dental services that are inextricably linked to, and substantially related and integral to the clinical success of, an otherwise covered medical service." Specifically, the following dental services are proposed to be included as examples of covered services, whether performed in an inpatient or outpatient setting:

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

The proposal would also allow payment for ancillary services in connection with covered dental services, such as x-rays, anesthesia administration, use of an operating room, or other facility services. CMS is seeking feedback on whether dental services should also be covered when provided in connection with other medical conditions.

Medicare Shared Savings Program

The 2023 PFS Proposed Rule also addresses proposed changes to the Medicare Shared Savings Program in an effort "to advance CMS' overall value-based care strategy of growth, alignment, and equity." The changes are in large part a response to recent trends that indicate the program as not as effective as it could be. In particular, growth in the accountable care organizations (ACOs) has stagnated, and certain populations are underrepresented in the program. Accordingly, the proposed changes seek to incentivize increased participation, even for providers who require significant up-front investment.

One significant change reflected in the proposal is the introduction of advance shared savings payments for ACOs that are new to the Shared Savings Program and that serve underserved populations. This would allow for a one-time fixed payment of $250,000 and quarterly payments for the first two years of the 5-year agreement period. These advance payments would be recouped when the ACO begins to achieve shared savings in the current agreement period and, if any balance remains, in the subsequent five-year agreement period. If no shared savings are achieved, the advance payments would not be recouped, unless the ACO terminates during the agreement period. The advance payments would enable eligible providers to invest in appropriate infrastructure, increase staffing, or provide care for beneficiaries, which may include addressing social needs. The proposal calls for an initial application period in 2023, with a program start date of January 1, 2024.

The proposal also allows for inexperienced ACOs to utilize a one-sided risk model for the initial five-year agreement, with a possibility for an additional two years of one-sided risk before transitioning to full risk model. Additionally, CMS is proposing modifications to the benchmark methodology. These changes include:

- Incorporating a prospective, external factor in growth rates to update the historical benchmark;
- Adjusting ACO benchmarks to account for prior savings;
- Reducing the impact of the negative regional adjustment;
- Calculating county-level fee-for-service expenditures to reflect differences in prospective assignment and preliminary prospective assignment with retrospective reconciliation;
- Improving the risk adjustment methodology to better account for medically complex, high-cost beneficiaries and guard against coding initiatives;
- Expansion of eligibility criteria to allow increased opportunities for low revenue ACOs to share in savings; and
- Ongoing consideration of concerns about the impact of the COVID-19 PHE on ACO's expenditures.

Another modification to the Shared Savings Program is to change from an all-or-nothing approach to eligibility for shared savings to a sliding scale approach, beginning January 1, 2023. Also, a health equity adjustment could provide bonus points for ACOs who achieve high quality measures while serving a higher proportion of underserved or dually eligible beneficiaries. Finally, the proposal includes modifications

intended to reduce the administrative burden for participating ACOs.

What's Next?

While some of the provisions contained in the 2023 PFS proposed rule may be welcome changes, the overall response from the physician community has been frustration that the decreased reimbursement resulting from the reduced conversion factor will be inadequate, particularly in light of the current economic climate. With inflation at a 40-year high, practices are already struggling to maintain financial stability, even before the Medicare decrease – which will be further compounded by the return of sequestration and the introduction of PAYGO cuts. It has been widely reported that nurses are leaving the profession in record numbers, so practices must offer competitive compensation levels to attract and retain their clinical support staff. Administrative support staff costs are increasing as well, as many lower paid positions are getting lured to jobs in other industries. Meanwhile, supply costs continue to rise and physician practices must also expend resources to ensure they remain compliant with all regulatory requirements.

Many physician advocacy organizations have already begun lobbying for Congress to intervene and provide a long-term fix for the broken Medicare Physician Fee Schedule system. We expect these efforts to intensify as we move closer to the end of the year. Unfortunately, it is likely that any legislative relief that may arise will once again, for the third year in a row, come at the last minute. The conversion factor adjustment for 2021 was included in legislation that was signed into law December 27, 2020, while the relief for 2022 was included in legislation enacted December 10, 2021. The deadline for submitting formal comments to CMS in response to the 2023 PFS Proposed Rule is September 6, with a final rule expected in early November. Any legislative intervention would likely not occur until after the November mid-term elections and after the release of the final rule. Until then, practices must plan for the worst and hope for the best.

JTaylor's healthcare consulting team includes a group of professionals who specialize in physician practice dynamics, as well as individuals who focus on strategy and operations. If you are interested in finding out how the 2023 PFS Proposed Rule would impact reimbursement for your practice, with its unique service and payer mix, we can help. Our team can also support you from a strategic perspective as you plan for reduced reimbursement. To find out more or to contact a member of our team, please visit our website.

Resources:

- Calendar Year (CY) 2023Medicare Physician Fee Schedule Proposed Rule fact sheet
- Quality Payment Program fact sheet
- Medicare Shared Savings Program Proposals fact sheet
- Strengthening Behavioral Health Care for People with Medicare blog
- CY 2023 Medicare Physician Fee Schedule Proposed Rule